SUPPLEMENTAL SECURITY INCOME LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

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SUPPLEMENTAL SECURITY INCOME LEGISLATION

WEDNESDAY, AUGUST 3, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON PUBLIC ASSISTANCE AND
UNEMPLOYMENT COMPENSATION,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to notice, in room H-137, the Capitol, Hon. Harold Ford (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press release of Thursday, July 21, 1983]

HON. HAROLD FORD (D., TENN.), CHAIRMAN OF THE SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION, COMMITTEE ON WAYS AND MEANS, ANNOUNCES HEARINGS AT WHICH INVITED WITNESSES WILL TESTIFY ON PENDING SUPPLEMENTAL SECURITY INCOME LEGISLATION

The Honorable Harold Ford (D., Tenn.), Chairman of the Subcommittee on Public Assistance and Unemployment Compensation, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will conduct a hearing on bills pertaining to the Supplemental Security Income (SSI) Program. The hearing will be held on Wednesday, August 3, 1983. It will begin at 10:00 a.m. in room B-318 of the Rayburn House Office Building [subsequently changed to room H-137, the Capitol].

The presentation of testimony at the hearing will be by invitation only. Others may submit written testimony for inclusion in the record of the hearing by following the procedures described below. Invited witnesses will be asked to testify on the following bills:

(1) Title III of H.R. 2354 (Mr. Ford), that makes permanent the current temporary program of special benefits for working disabled SSI recipients; and

(2) H.R. 3074 (Mr. Stark, et al), that would suspend the current periodic reviews of mentally impaired SSI recipients, along with other amendments.

In addition, invited witnesses will be asked to comment on specific provisions and policy changes relevant to the SSI program that are contained in the proposed Disability Benefit Reform bill that the Social Security Subcommittee is scheduled to consider the week of July 25, 1983.

PROCEDURE TO BE FOLLOWED FOR SUBMITTING WRITTEN COMMENTS

Any interested person or organization may file a written statement for inclusion in the printed record of the hearing. Persons submitting written comments should submit at least six copies by the close of business, Wednesday, August 17, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Those wishing to have their written statements distributed to the press and interested public may submit 50 additional copies for this purpose if provided to the Committee office before the hearing begins.

Chairman FORD. The Subcommittee on Public Assistance and Unemployment Compensation will come to order for the purposes of public hearings today on SSI disability issues.

The Chair would like to say that the room is rather small and we apologize for not having enough seats. I notice there were several people in the hallways. Hopefully, later today we will be able to move back to the Public Assistance and Unemployment Subcommittee room in the Rayburn Building.

Today's hearing by the Subcommittee on Public Assistance and Unemployment Compensation is concerned with income assistance to the disabled under the supplemental security income program. As a part of the Disability Amendments of 1980, Congress enacted certain amendments to the SSI disability program intended to lessen the work disincentives for disabled SSI recipients, who risk the loss of SSI and medicaid-related increases in spite of the continuation of their disability.

These provisions, authorized in section 1619 of the Social Security Act, will expire on December 31 of this year. Legislation has been introduced to make this program permanent, and one of the purposes of our hearing today is to hear testimony regarding the impact of this program.

The subcommittee has heard of a number of cases where social services and rehabilitation agencies and the disabled who could have benefited from section 1619 did not know about the availability of the option to continue to receive special SSI benefits and/or medicaid when they were able to work in spite of their disability. We need to know the reason for this and, if necessary, take corrective action by this committee as well as the Congress.

This hearing is taking place at a time when there is continuing concern for the number of individuals who have been denied SSI benefits or who have lost their disability benefits because of the continuing disability investigations being conducted under the criteria of disability now being used by the Social Security Administration. There are over two million individuals drawing SSI benefits on the basis of disability.

Eligibility for SSI benefits is based not only on a finding of disability, but also is only available to those who meet the stringent income and asset criteria for SSI. Over one-third of the current recipients of SSI disability benefits qualify on the basis of minimal impairments.

When the GAO reported this spring that the disability reviews were having particularly adverse impacts on the mentally disabled, it became evident some action must be taken to protect the SSI disabled recipients, including those who are concurrent recipients of disability insurance.

Included in the legislation being considered as related to SSI and by the Social Security Subcommittee in their markup of disability insurance legislation are provisions to provide for the temporary delay in reviews of all mental impairments and disabilities until the listings have been revised and outside advisory groups consulted. I must say that the Subcommittee on Social Security is in fact in session this morning, with a markup session, as I understand it, this afternoon, and will probably report legislation from that subcommittee some time in the very near future.

Some of the witnesses who have been invited to testify today have been asked to comment on the application to SSI of the specific provisions and policy questions being considered by the Social Security Subcommittee in their markup on disability insurance legislation. Such suggestions will be helpful to the subcommittee in its future markup of SSI disability legislation.

I would like to express my appreciation to all of those witnesses who will be testifying before the Committee today.

We will in just a few minutes call up the first witness, but at this time the Chair would like to recognize the ranking minority member of the subcommittee, Mr. Campbell.

Mr. CAMPBELL. I would like to take this opportunity to welcome Mr. Paul Simmons from the Social Security Administration, as well as others who will be presenting testimony today which we hope will enlighten us as to the problems facing the recipients of the supplemental security income program.

We have been successful as a society in the last decade in providing some opportunities for the disabled to receive the skills to eventually enter the work force, especially in the area of chronic mental illness and retardation. We have encouraged individuals to work in sheltered workshops or supervised work environments and then to eventually participate in competitive employment.

With this as our focus as a humane society, we want to make sure that we have in place the mechanisms to support this population that, because of the nature of their disabilities, have an inconsistent work history. The administration of the disability program is complex and it is difficult to legislate a program that will fit all the conflicting needs of the individuals we are best trying to serve.

However, our objective is to find ways to make sure that those who are truly disabled receive the support, both in income services and the other services that are needed, to encourage their personal independence. It is my sincere hope that testimony heard before this subcommittee today will help us in the difficult task before us.

Chairman FORD. Thank you, Mr. Campbell.

We will now have Mr. Paul Simmons, who is the Deputy Commissioner of Programs and Policies for the Social Security Administration from the Department of Health and Human Services.

Mr. Simmons, you are recognized at this time for testimony.

STATEMENT OF PAUL B. SIMMONS, DEPUTY COMMISSIONER FOR PROGRAMS AND POLICY, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY RHODA M. G. DAVIS, ACTING ASSOCIATE COMMISSIONER FOR SUPPLEMENTAL SECURITY INCOME; PATRICIA OWENS, ACTING ASSOCIATE COMMISSIONER FOR DISABILITY; AND ELMER SMITH, DIRECTOR, OFFICE OF ELIGIBILITY POLICY, HEALTH CARE FINANCING ADMINISTRATION

Mr. SIMMONS. I am accompanied today by Rhoda Greenberg-Davis, who is Associate Commissioner for Supplemental Security Income at the agency, and Patricia Owens, who is the Associate Commissioner for the Disability Program at Social Security.

I appreciate this opportunity to discuss the two bills before your subcommittee and also some of the proposals that are currently

being considered by the Subcommittee on Social Security. As you pointed out, they are completing markup, we think, this afternoon. As you are aware, we have been working closely with that subcommittee on changes in the disability decisionmaking process, particularly in the periodic review process.

We share your concern that the disability process itself be an equitable and humane process and not treat unfairly the very population the disability programs are intended to serve. With that thought in mind, I propose to share with you and the subcommittee members our views on various proposals and summarize some of the reforms and changes we have initiated in the continuing disability review [CDR] process which we believe will go far in alleviating some of your concerns.

Mr. Chairman, first let me discuss the proposal in your bill, as well as that in Mr. Stark's bill, to make permanent the 3-year pilot project authorized under section 1619 (a) and (b) of the act, that was passed in the 1980 disability amendments.

This section provides special conditions of eligibility for SSI benefits and medicaid for disabled or blind SSI recipients who work and who would otherwise lose their eligibility. As you know, these provisions were intended to encourage individuals with serious impairments to attempt to work by continuing their status as SSI recipients under certain circumstances.

Under section 1619(a), disabled SSI recipients who work are eligible for special cash payments and SSI status only if: first, their earnings are above the so-called substantial gainful activity level, the point at which an individual is generally no longer considered disabled; second, they have countable income under the breakeven level—that is, the point at which the SSI recipient would be ineligible based on income alone; and third, the individual continues to have a disabling impairment.

In these cases, no new application form or special action by the recipient is required and there is no interruption in benefits or medicaid eligibility. Recipients who lose regular SSI status are routinely notified that they are eligible for these special benefits.

Although the intent of section 1619(a) has been meritorious, we oppose extending the life of this provision as it is. Very few SSI recipients, fewer than 300 in any given month, have been eligible under this provision, leading us to question its overall effectiveness as a work incentive per se.

In addition, we question providing a special benefit to the disabled who work above substantial gainful activity levels after the 9-month trial work period. These are recipients who, through their work activity, have demonstrated that they are capable of substantial gainful activity and therefore should no longer be considered disabled and eligible to receive benefits.

Extending the life of this provision would create a permanent category of benefits for the working poor and would add about $7 million in SSI costs to the federal budget over the next 5 years. Although this is a relatively small amount, we do not believe this expenditure appropriate because these recipients have successfully demonstrated they no longer meet what is a basic requirement for eligibility, in both this program—and the title II program, I might add.

We also oppose an extension of section 1619(b). This section of the law also was enacted on a 3-year demonstration basis. It permits, for purposes of medicaid coverage under title XIX, the continuation of SSI status for blind or disabled recipients who work despite impairments, but whose earnings preclude either regular SSI benefits or special cash payments under section 1619(a). It was hoped that SSI program costs would decline if the SSI recipient did not have to face a loss of medicaid coverage of his health care costs if he increased his earnings.

As with section 1619(a), the objective of 1619(b)—to encourage some severely handicapped people to continue to work—may be meritorious. However, the effect of this proposed change would be to establish permanent medicaid coverage—under a federal mandate, in which the States have no say—for many individuals who, although seriously impaired, have demonstrated the ability to work in a competitive environment and may have substantial earnings.

In some States, for example, you can earn up to $19,000 a year and still retain eligibility for medicaid under 1619(b). If section 1619 (a) and (b) were made permanent, we estimate Medicaid costs would increase through fiscal year 1988 by approximately $36 million in Federal expenditures and $30 million in additional State expenditures.

We are examining, I should point out, a possible alternative position on this where, for example, we might come down on the side of making a provision like this optional with the States, to allow the States to set a special eligibility level for a certain class of people if they so desired, and that would give them a say in the decision, which they do not have now.

As an alternative, if the committee does move and the Congress does move to make some version of this plan permanent, we would prefer to see it put into the law with some kind of a time-certain cutoff date, parallel to medicaid coverage of title II disability beneficiaries. Now you retain medicare eligibility for 2 years after leaving the title II rolls and going back to work. There is a 2-year cutoff date. That way this would not become an open-ended program that could allow a person to stay on the rolls forever no matter what the income.

And as I pointed out, in some States people could be eligible for medicaid uner 1619(b) and their incomes could be as high as $16,000 to $19,000. In some other States it is as low as $7,000, which creates a disparity around the country.

Turning to the disability determination process itself, since the implementation of periodic review, this Administration has recognized the need for changes in the disability decisionmaking process. I should mention at the outset that the periodic review has not been targeted on the SSI population, except where the SSI recipient also receives social security disability benefits.

Some of the hardships to beneficiaries that have resulted have stemmed from the review process itself. The sheer volume of reviews has obviously highlighted flaws in that process—which, as you know, for 26 years was totally paper-oriented; a person never saw a decisionmaker until the end of the process. We have moved continuously to correct these flaws through a long series of administrative reforms beginning back in early 1982.

A list of actions taken up until June 1983, when Secretary Heckler announced further reforms, is included as an appendix to my statement. Our major priority is to make the disability decision-making process as responsive to the needs and concerns of the disabled as possible, and to make that program more humane in the process of doing so. That is the main thrust of the initiatives announced last year by social security Commissioner Svahn and 2 months ago by Secretary Heckler.

We have reduced, for example, the number of beneficiaries to be reviewed by expanding our definition of permanent disability. Those now exempt include substantial numbers of beneficiaries with mental impairments, who have been particularly hard hit by periodic review.

When we took office, Mr. Chairman, there were about 675,000 people in the title II program who were classified as permanently disabled. There are now over one million because of our action.

Based upon program experience, SSA has concluded that mentally impaired beneficiaries with functional psychotic disorders are the most prone to incorrect terminations. Therefore, we have suspended review of such cases—and they represent about two-thirds of all mental impairment cases—pending consultation with mental health experts on revisions to our present standards and procedures for all categories of mental impairments.

Once revised standards are adopted, we will take another look at beneficiaries whose benefits have been terminated over the past 2 years, those with functional psychotic disorders, in order to make sure that they were not incorrectly terminated.

The process of revising those standards has begun, I am pleased to report. We had a major meeting last week, the first of what will be many, with everyone from the American Psychiatric Association to all of the other professions involved in this most controversial area. And we are hopeful that we will arrive at a common ground and a commonly acceptable standard for review.

The Social Security Administration will now use a random selection process to identify cases for the periodic reviews. We had been selecting cases based on a profile of characteristics found to be common to those most likely not to be disabled. One of the results of that was a very high termination rate early in the program and a clogging of the ALJ pipeline. A lot of people are waiting a long time for a hearing at the administrative law judge level.

While we clearly did not target reviews on the mentally impaired as a matter of policy, the use of the profiles resulted in a disproportionate number of mental impairment cases being selected for review, since such cases were more likely to fit the profile than cases involving physical impairments. Random selection should eliminate any lingering concerns that we were deliberately targeting reviews on the mentally impaired.

Finally, the Social Security Administration is accelerating its top-to-bottom review of disability policies and procedures, in areas other than mental impairments as well, in consultation with appropriate experts and States, who after all run the disability determination program for us. For example, we are reviewing the eligibility criteria in both physical and mental impairment cases, and whether the "nonsevere impairment" standard needs to be

changed to better insure that a full review of the person's age, education and work history is undertaken before any decision is made.

A major part of this review of our policies and procedures is examining whether a medical improvement requirement for terminating disability beneficiaries should be adopted. We would like to work with this committee and the Subcommittee on Social Security to develop standards that take into account medical improvement without permitting clearly ineligible beneficiaries to remain on the rolls. As we have stated to the Subcommittee on Social Security, it may be desirable to spell out such a standard by statute to avoid prolonged litigation on this subject, which is probably what will happen if we do it by regulation.

However, we do not think that a legislative moratorium on reviewing mental impairment cases in either the social security program or the SSI program is needed at this point because we already have initiated administratively a partial moratorium covering the most controversial of the cases. This moratorium will remain in effect until we review all of our standards and procedures in these cases.

We also think that many of the other reforms we have instituted will have a favorable impact on the mentally impaired and obviate the need for Congress to enact a moratorium for either social security or SSI case reviews.

I would like to mention one other provision that is in both Representative Stark's bill; and the Subcommittee on Social Security's bill; that is, the requirement that in mental impairment cases a qualified psychiatrist or psychologist would have to complete the medical portion of the disability evaluation and the assessment of residual functional capacity in every single case.

This provision is troublesome in two respects: First, States have historically had difficulty in obtaining adequate psychiatric resources. In spite of efforts by us and the States and the American Psychiatric Association even trying to encourage its own members to help the States, it has been difficult to recruit psychiatrists and increase the number of psychiatric review hours. Enactment of this provision could result in delays simply because a psychiatrist or a psychologist is not available to assess cases.

Second, SSA does not think it is necessary to have a psychiatrist or a psychologist participate in every single mental impairment case, since many cases require only a simple medical assessment. Many physicians have a subspecialty in psychiatry and could make the appropriate medical assessment.

I might add that the Subcommittee on Social Security has tentatively agreed to revise this requirement and make it apply only to unfavorable decisions, which would make the provisions much easier to administer and much less objectionable from the point of view of using scarce resources.

Finally, I have been asked by your staff to comment briefly on a demonstration project we developed. Under the authority of section 505 of the 1980 amendments, we will be conducting a demonstration of transitional employment training for recipients of SSI who are mentally retarded. Mental retardation, as you point out, is the leading cause of disability among SSI children and young adults, and accounts for about 70,000 new SSI awards annually.

Although many retarded individuals work and support themselves, many others who have the capacity to work are unable to hold jobs because they may lack common social skills in relating to coworkers, have difficulty adhering to time schedules or following directions, or may exhibit other inappropriate behavior.

Transitional employment training usually takes place in a real job setting, usually in a private firm. The largest difference between transitional employment and other forms of rehabilitation for the retarded, such as sheltered workshops, is the environment of ordinary workers.

The training under this demonstration project will be conducted through grants to training organizations. These organizations will place the trainees in training jobs, provide a counselor/supervisor to coach them for about 6 months, and arrange their permanent placement, frequently in the same job in which they were trained.

Several transitional employment programs for the retarded have begun over the past 5 years, and we understand that about half of their trainees successfully complete the program and graduate to permanent jobs. That is a remarkable achievement.

We hope to demonstrate whether this experience can be replicated for levels of retardation severe enough to qualify a person for SSI. I should add that the 300 to 500 people who will participate in this project are more severely disabled, on average, than the handicapped people in other such programs. We think this will be a successful demonstration if 25 percent of our participants graduate to permanent jobs.

SSA is planning a rigorous cost-benefit analysis, to be conducted under contract, that will focus on both the long- and short-term results of the training relative to the experience of a group of recipients who did not get such training. We expect the contract for the design of the project to be awarded as early as next month and the short-term evaluation should be available to the Congress in 1985.

This project has been budgeted at a cost of about $2.8 million and it has been put together in consultation with advocates for the retarded, and I think you will find that you will be generally pleased with the shape of the project and the plans we have for it. This project holds promise for leading to substantial reductions in SSI outlays, as more mentally retarded people become self-supporting.

I thank you and the members of the subcommittee for this opportunity. I will be glad to answer any questions you may have.

[The prepared statement of Mr. Simmons follows:]

STATEMENT OF PAUL B. SIMMONS, DEPUTY COMMISSIONER OF SOCIAL SECURITY

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to discuss the Supplemental Security Income (SSI) disability proposals in the two bills your subcommittee is considering today, H.R. 2354 and H.R. 3074. Also, some of my remarks will extend to proposals currently being considered by the Subcommittee on Social Security.

As you are aware, we have been working closely with the Committee on Ways and Means on changes in the disability decisionmaking process, particularly in the periodic review process. We share your concern that the disability process itself be an equitable and humane process and not treat unfairly the very population the disability programs are intended to serve. With that thought in mind, Mr. Chairman, I propose to share with you and the subcommittee members our views on various proposals and summarize some of the reforms and changes we have initiated in the

continuing disability review (CDR) process which we believe will go far in alleviating some of your concerns.

SECTION 1619 (a) AND (b)

First, let me discuss the proposal in your bill, Mr. Chairman, as well as in Mr. Stark's bill to make permanent the 3-year pilot project authorized under section 1619 (a) and (b) of the Social Security Act. This section, which was enacted as part of the 1980 disability amendments, provides special conditions of eligibility for SSI benefits and Medicaid for disabled or blind SSI recipients who work and who would otherwise lose their eligibility. As you know, these provisions were intended to encourage individuals with serious impairments to attempt to work by continuing their status as SSI recipients under certain circumstances.

Under section 1619(a), disabled SSI recipients who work are eligible for special cash payments and SSI status if: (1) earnings are above the substantial gainful activity level, the point at which an individual is generally no longer considered disabled; (2) countable income is under the breakeven level—that is, the point at which the SSI recipient would be ineligible based on income alone; and (3) the individual continues to have a disabling impairment. In these cases, no new application form or special action by the recipient is required and there is no interruption in SSI benefits or Medicaid eligibility. Recipients who lose regular SSI status are routinely notified that they are eligibile for these special benefits.

Although the intent of section 1619(a) may have been meritorious, we oppose extending the life of this provision. Very few SSI recipients—fewer than 300 in any given month—have become eligible under this provision, leading us to question its overall effectiveness as a work incentive. In addition we question providing a special benefit to the disabled who work above substantial gainful activity levels after the 9-month trial work period. These are recipients who, through their work activity, have demonstrated that they are capable of substantial gainful activity and, therefore, should no longer be considered disabled and eligible to receive benefits. Extending the life of this provision would create a new class of program benefits for the working poor and would add about $7 million in SSI costs to the Federal budget over the next 5 years. Although this is a relatively small amount, we do not believe this expenditure is appropriate because these recipients have successfully demonstrated that they no longer meet what is a basic requirement for eligibility.

We also oppose an extension of section 1619(b). This section of the law also was enacted on a 3-year demonstration basis. It permits for purposes of Medicaid coverage under title XIX the continuation of SSI status for blind or disabled SSI recipients who work despite impairments but whose earnings preclude either regular SSI benefits or special cash payments under section 1619(a). It was hoped that SSI program savings would increase if the SSI recipient continued to work when his health care costs were covered by Medicaid.

As with section 1619(a), the objective of section 1619(b)—to encourage some severely handicapped people to continue to work—may be meritorious. However, the effect of this proposed change would be to establish permanent Medicaid coverage for many individuals who, although seriously impaired, have demonstrated the ability to work in a competitive environment and may have substantial earnings. If section 1619(a) and (b) were made permanent, we estimate Medicaid costs would increase through fiscal year 1988 by approximately $35.9 million in Federal expenditures and $29.5 million in additional State expenditures.

IMPROVING THE DISABILITY PROCESS

Now, Mr. Chairman, turning to the disability process, since the implementation of periodic review, this administration has recognized the need for changes in the disability decisionmaking process. (I should mention at the outset that the periodic review has not been targeted on the SSI population, except where the SSI recipient also receives Social Security disability benefits.) Some of the hardships to beneficiaries that have resulted have stemmed from the review process itself. The sheer volume of reviews has highlighted obvious flaws in that process—flaws which we have moved continuously to correct through a long series of administrative reforms beginning in early 1982. (A list of actions taken up to June 1983 is included as an appendix to my statement.) Our major priority is to make the disability decisionmaking process as responsive to the needs and concerns of the disabled as possible. Making the program more humane is the main thrust of the initiatives announced by Secretary Heckler in early June. Let me mention sme of these initiatives:

We have reduced the number of beneficiaries to be reviewed by expanding our definition of permanent disability. Those now exempt include substantial numbers

of beneficiaries with mental impairments who have been particularly hard hit by periodic review.

Based on program experience, SSA has concluded that mentally impaired beneficiaries with functional psychotic disorders are the most prone to incorrect terminations. Therefore, we have suspended review of such cases (representing two-thirds of all mental impairment cases) pending consultation with mental health experts on revisions to our present standards and procedures for all categories of mental impairments. Once revised standards are adopted, we will take another look at terminated beneficiaries with functional psychotic disorders in order to make sure that they were not incorrectly terminated.

SSA will now use random selection to identify cases for periodic CDR. We had been selecting cases based on a profile of characteristics found to be common to those most likely not to be disabled. While we clearly did not target reviews on the mentally impaired, the use of profiles resulted in a disproportionate number of mental impairment cases being selected for review, since such cases were more likely to fit the profile than cases involving physical impairments. Random selection should eliminate concerns that SSA is deliberately targeting reviews on the mentally impaired.

Finally, SSA is accelerating its top-to-bottom review of disability policies and procedures, in consultation with appropriate experts and the States. For example, we are reviewing the eligibility criteria in both physical and mental impairment cases, and whether the "non-severe impairment" standard needs to be changed to better ensure that a full review of the person's age, education and work history is undertaken before any decision is made.

A major part of the top-to-bottom review of our policies and procedures is examining whether a medical improvement requirement for terminating disability beneficiaries should be adopted. We would like to work with this committee to develop standards that take into account medical improvement without permitting clearly ineligible beneficiaries to remain on the rolls. As we have stated to the Subcommittee on Social Security, it may be desirable to spell out such a standard by statute to avoid prolonged litigation on this subject.

However, we do not think that a legislative moratorium in mental impairment cases in either the Social Security program or the SSI program is needed because we already have initiated administratively a partial moratorium. This moratorium will remain in effect until we review our standards and procedures in mental impairment cases. We also think that many of the other reforms we have instituted will have a favorable impact on the mentally impaired and obviate the need for Congress to enact a moratorium for either Social Security or SSI.

Mr. Chairman, I would like to mention one other provision that is in both Representative Stark's bill and the Subcommittee on Social Security bill. That is, in mental impairment cases, a qualified psychiatrist or psychologist would have to complete the medical portion of the disability evaluation and the assessment of residual functional capacity. This provision is troublesome in two respects. First, States have had difficulty in obtaining adequate psychiatric resources in spite of efforts by SSA and the States to recruit psychiatrists and increase the number of psychiatric review hours. Enaktment of this provision could result in delays simply because a psychiatrist or psychologist is not available to assess cases.

Second, SSA does not think it is necessary to have a psychiatrist or psychologist participate in every mental impairment case since many cases require only a simple medical assessment. Many physicians have a subspecialty in psychiatry and could make the appropriate medical assessment. I might add that the Subcommittee on Social Security has tentatively agreed to apply this requirement of a psychiatrist's review only in unfavorable decisions, which would make the provision less objectionable.

SSI DEMONSTRATION PROJECT

Finally, Mr. Chairman, I had been asked by your staff to comment briefly on a demonstration project that SSA has developed. Under the authority of section 505 of the 1980 disability amendments, SSA will conduct a demonstration of transitional employment training for recipients of SSI who are mentally retarded. Mental retardation is the leading cause of disability among SSI children and young adults, and accounts for about 70,000 new SSI awards annually. Although many retarded individuals work and support themselves, many others who have the capacity to work are unable to hold jobs because they may lack common social skills in relating to coworkers, have difficulty adhering to time schedules or following directions, or may exhibit other inappropriate behavior.

Transitional employment training takes place in a real job setting, usually in a private firm. The clearest difference between transitional employment and other forms of rehabilitation for the retarded, such as sheltered work, is the environment of ordinary workers.

The training under this demonstration project will be conducted through grants to training organizations. These organizations will place the trainees in training jobs, provide a counselor/supervisor to coach them for about 6 months, and arrange their permanent placement, frequently in the same job in which they were trained.

Several transitional employment programs for the retarded have begun over the past 5 years, and we understand about half their trainees successfully complete training and graduate to permanent jobs. We hope to demonstrate whether this experience can be replicated for levels of retardation severe enough to qualify a person for SSI. I should add that the 300–500 people who will participate in this demonstration are more severely disabled, on average, than the handicapped people in other transitional employment programs. We think this will be a successful demonstration if 25 percent of the participants graduate to permanent jobs.

SSA is planning a rigorous cost-benefit analysis, to be conducted under contract, that will focus on both the long- and short-term results of the training relative to the experience of a group of recipients who did not get such training. We expect the contract for the design of the project to be awarded next month. The short-term evaluation of the demonstration will be presented to the Congress is 1985.

Let me add that this demonstration project, which has been budgeted at a cost of $2.8 million, has met with favorable response from advocates for the retarded. This demonstration project holds promise for leading to substantial reductions in SSI outlays, as more mentally retarded people become self-supporting.

Mr. Chairman, I again thank you and the members of the subcommittee for this opportunity. I will be glad to answer any questions you may have.

ATTACHMENT 1.—MAJOR CDI REFORMS INITIATED PRIOR TO JUNE 1983 INITIATIVES (ANNOUNCED BY SECRETARY HECKLER ON JUNE 7)

1. In October 1982, SSA started using a new procedure for beginning a CDI review: each beneficiary has a face-to-face interview with an interviewer in a local Social Security office. The interviewer explains how the review works and what the beneficiary's rights are, obtains information about the beneficiary's medical care and treatment and current condition, and—in some cases—concludes the review process where it is clearly warranted based on the beneficiary's current medical condition.

2. SSA is stationing State agency employees to serve as disability consultants in many SSA local offices with the highest workloads to provide additional disability expertise. New interview forms and guides have been issued to local office interviewers and numerous State agency disability consultants are already on site.

3. SSA established pilot programs in three States so that SSA can smoothly implement the provision in Public Law 97–455 providing an opportunity for a face-to-face evidentiary hearing at reconsideration. Prior to the legislation, SSA had been planning to implement this change on an administrative basis.

4. In March 1982, SSA initiated a policy of determining that, in general, a person's disability ceases as of the time the beneficiary is notified of the cessation. This change reduces situations where the beneficiary is faced with the need to pay back past benefits because of a retroactive determination.

5. Since May 1982, SSA has mandated that States review all medical evidence available for the past year—a directive which ensures that every State is looking at every piece of evidence that might be pertinent to a case.

6. SSA has taken many actions to improve the quality of consultative examination purchases by the government in cases where medical evidence from a person's physician is unavailable or incomplete.

7. Since March 1982, SSA has required State agencies to furnish detailed explanations of their decisions in all cases in which a person's disability has ceased.

8. To improve the quality of determinations in difficult cases where it is necessary to determine a person's capacity to do work-related activities despite a severe impairment, SSA is requiring that the determinations as to residual functional capacity be more detailed and explicit so that the basis for the final decision is clear.

9. To ensure quality in CDI cases, SSA conducts a quality review of a sample of cases before benefit are stopped. In addition, to demonstrate the importance of quality in the CDI process, SSA established an interim accuracy goal for the State agencies. SSA is also studying terminations to find out what kinds are especially error-prone.

10. SSA has consistently monitored State agency resources and workloads closely and adjusts the flow of cases to the individual States to avoid backlogs when problems have arisen in their acquiring adequate resources.

11. SSA refined the selection criteria for CDI reviews so that more beneficiaries who are permanently disabled were identified and exempted from the 3-year review process.

12. To modernize the CDI process and make it more responsive to beneficiaries' needs, SSA has reached out to many public and private interest and professional groups to discuss their concerns about the disability program and to obtain their suggestions for improvements. SSA has also met extensively with State agency administrators and field personnel to exchange ideas for improvements.

13. SSA has concentrated efforts on the need for special handling of cases involving psychiatric impairments:

SSA has also encouraged the States to increase the number of psychiatrists on their staffs and has asked the American Psychiatric Association (APA) for assistance in recruiting psychiatrists for the States.

SSA and the APA have agreed to exchange research and development information in the field of mental illness.

SSA has issued instructions emphasizing the importance of evaluating chronic mental impairments in a long-range context. The instructions require that disability adjudicators consider the person's longitudinal history and obtain all available medical evidence, past and current, to determine the frequency of the person's symptoms and the adequacy of his functioning.

14. SSA has underway a study to test the value of obtaining more than one special mental status examination in cases where evidence from the beneficiary's treating source is incomplete or inadequate. This is intended to determine whether a person's mental condition can drastically change from one day to another. One criticism of SSA's practice of getting only one mental status examination is that it gives a misleading "snapshot" of a person.

15. SSA has been issuing Social Security rulings to make sure that all disability decisionmakers—State agencies, ALJ's and the Appeals Council—follow the same standards of adjudication. These rulings are in accord with existing law and regulation and do not establish new standards.

16. SSA has added more than 140 Administrative Law Judges to what is already perhaps the largest single administrative adjudicative system in the world, bringing their total number to almost 800 and providing them with significantly more support staff to help reduce the backlog of cases that has been a chronic problem in past years.

17. SSA has issued to its field offices and to State agencies procedures for handling potential suicide situations to make sure that SSA and State agency personnel identify and give appropriate attention to beneficiaries who may be in this situation.

Chairman FORD. Thank you very much, Mr. Simmons. Your testimony is before the committee. I am sure members of the panel will have some questions.

I have one. You indicated in your testimony that the administration does not favor extending the 1619 program for the working disabled. You give estimates of how much it would cost to extend the program, but you give no information as to how much has been expended or saved because of the increased work incentive since the program began in 1981.

Do you have such figures available with you today, and if so what types of evaluations have been conducted?

Mr. SIMMONS. We have given what data we have to your staff. One of the problems we have with this program and almost every other program is the sheer lack of data on what is going on. We really do not know. I think over the years it has been almost scandalous.

Chairman FORD. The staff has received what, now?

Mr. SIMMONS. What data we have has been given to you. We have very little on this program. There was never any money earmarked to do a study on it. There were only about 300 cases in any

one month. It is a very small sample and we just have anecdotal evidence and anecdotal guesses. Our researches have trouble estimating what the total impact of this would be, simply because of the lack of data.

One of the things we are doing in the agency to overcome this kind of problem is we have dismantled our old Office of Research apparatus and we fashioned it around the three program areas that we administer, in hopes that by bringing the research arm closer to the program arm we will have more focused research and better data collection.

We are also building into our new systems design, on which we are spending about $600 million, by the way, a capability to do the kinds of things we cannot do now simply because we do not have the capacity to do it.

Chairman FORD. I was talking with staff about the information we were supposed to receive and I understand from staff it was about 6,000 to continue medicaid. Is that correct?

Mr. SIMMONS. About 6,000 people in the medicaid only portion, and about 300 recipients in any one month in the benefit portion of the program.

Chairman FORD. How can you estimate the cost for the future when you cannot——

Mr. SIMMONS. We can estimate, if the staff tells us growth will probably be the same as it has been, it will be that amount over those years. They are not sure. It is not a solid estimate.

One of the things I have sent back to the drawing boards is, could we support a provision in the law that would say this kind of program would be optional to the States?

Chairman FORD. But you are given estimates of what it will cost for the future, is that correct?

Mr. SIMMONS. Yes, sir. The $36 million estimate is the staff's best guess of what it will cost in Federal expenditures through fiscal year 1988, maybe more or less.

Chairman FORD. But it is difficult for us to estimate what it has cost in the past, is that correct?

Mr. SIMMONS. That I do not know. Do we have that number?

Mr. SMITH. Mr. Chairman, I am Elmer Smith. I am Director of the Office of Eligibility Policy of the Health Care Financing Administration.

Health Care Financing actuaries have developed these costs, and because of the limited data base no one wants to say these are precise costs. They did the best they could with the number of persons now on the rolls, making assumptions about the number of people who would otherwise be terminated because their earnings rose above the substantial gainful activity level.

They took into account the growth in the civilian labor force. They took into account the kinds of health insurance which presumably persons would have when they became employed, that is, disabled persons would have through their employers. They took into account a variety of other factors and arrived at these numbers.

I have looked them over. I have dealt with numbers for a variety of years. And as I say, we do not want to say they are precise numbers, but given the limited data available to the actuaries, I think

it is about the best job that could be done. It certainly gives us an approximation of what the costs will be.

Chairman FORD. Staff, we have received no additional information, is that correct?

[Mr. Jensen nods in the negative.]

Chairman FORD. Mr. Campbell.

Mr. CAMPBELL. Mr. Chairman, let me go over to the other section with you just a moment, and I will back up to it.

On page 8 of your testimony you say, once revised standards are adopted, you will take another look at terminated beneficiaries with functional psychotic disorders in order to make sure they are not incorrectly terminated. What kind of timetable are we talking about?

Mr. SIMMONS. We have no idea exactly how long it will take to get agreement. I would hope within a matter of months we will have agreement on standards, but we just do not know. We are dealing in a very controversial area with several of the professions and interest groups, who all have a point of view on it.

In the best of all possible worlds, we might be able to have a new standard ready for comment by all concerned, say early this fall. If we can get agreement, we can put it into place overnight and go out and find all the people terminated in the past and re-review them.

Mr. CAMPBELL. Let me move you over to page 10 for a moment. You speak of the administrative moratorium here on the mental impairment cases. You say: "This moratorium will remain in effect until we review our standards and procedures in mental impairment cases."

Mr. SIMMONS. That is right.

Mr. CAMPBELL. Do you mean the same timeframe, all wrapped up into one?

Mr. SIMMONS. Yes, it is, sir.

Mr. CAMPBELL. So we are looking, then, at an earliest date this October?

Mr. SIMMONS. That would be an optimistic early date. The Ways and Means Subcommittee's own moratorium, their version of the moratorium proposal, gives us until April 1. We will take as long as it takes. We do not want to do this slap-dash or anything.

We are not trying to do it fast, too fast in order to save money or whatever. We are seriously concerned about it. It became clear after the first 18 months of experience that that was the one area, the functional psychotic disorders, where most of the controversy over the kinds of people who were coming off these rolls seemed to be, both among the professions and in our own view.

So we are taking a very serious look. We have a lot of very good outside people working with us and we have some experts from the National Institutes of Health working with us, and we think we will come up with something everyone can live with that will be a reasonable standard.

Mr. CAMPBELL. Are you also taking a look at what type of training you might provide for your claims representatives in various district offices? Because some of the biggest complaints we have are that they do not have any training at all about the differences between mental retardation and mental illness, and that we have

had one heck of a problem in trying to sort all of this out, and a lot of complaints have come back.

As a Member of Congress, there seems to be a pattern to the complaints that come through my office from people who claim to have been unfairly reviewed. Now, are we addressing this?

Mr. SIMMONS. Let me ask Ms. Owens, who is the associate commissioner in charge of that program, to comment on that.

Ms. OWENS. It is in the social security district offices, where the initial interviews are conducted. We have just released a training package to the district offices and in the delivery of that training package, we have asked for DDS examiners, who are the people from the States who apply the medical criteria and understand the distinctions between the different types of mental cases, to come in and present that kind of training to the district office interviewers.

So we are in the process of doing that kind of thing right now.

Mr. CAMPBELL. They would be updated on any type of revision or change before you tried to implement anything?

Ms. OWENS. Oh, yes, any kind of——

Mr. CAMPBELL. I think we get into trouble sometimes when we implement without people in the field knowing what is going on or what are the differences.

Ms. OWENS. We have made a commitment that any new change would be accompanied by a training package as the change is implemented; that we would not just announce the change, but the training would precede the actual change.

Mr. CAMPBELL. I am glad to hear that. I think that is absolutely necessary and I trust that it will be followed up vigorously to make sure that people who need the training get it.

You also state in here, in discussing mental impairment cases, that the Stark bill and the social security bill call for a qualified psychiatrist or a psychologist to complete the medical portion. Apparently there is opposition because of the numbers of psychiatrists and psychologists and their availability. I can speak for my State. I can see that that would be a great problem.

I am also interested that you offered the point that the social security—the Subcommittee on Social Security has tentatively agreed to apply it only as a review of unfavorable decisions.

Mr. SIMMONS. That is correct.

Mr. CAMPBELL. You would support that?

Mr. SIMMONS. Let me put it this way: We can live with it. It is a real problem out there. There are some States where the State fee schedules are just not enough to attract that kind of talent to come in and be consultants to the State agency.

In some cases, even with that provision, where a psychiatrist or a psychologist would have to make the cut on an unfavorable decision, we might have to send that case out of State, to another State where there is that availability, or to Baltimore where we have the availability, in order to make a judgment on that case.

It is very unfortunate. There are many cases where a physician who knows anything at all about psychiatry can make the decision and make a good decision. There are some that are so obvious you do not need to have a full specialist come in and run through the whole thing, because it will be a person whose medical records on their face say, yes, this person has a mental impairment and defi-

nitely is eligible for the program. And in those cases we would say—we always have a doctor make the decision one way or another—but we would like to have the freedom to use medical doctors with knowledge of psychiatry in those cases where there is no controversy.

Mr. CAMPBELL. What about your State mental facilities and the doctors and other employees who work there? Are they utilized in any way?

Mr. SIMMONS. I think in some States they are, but in some States there is probably a statutory provision forbidding them from having dual employment from the same State.

Ms. Owens can speak to that.

Ms. OWENS. There is a problem. Some States cannot. They can request evidence from their State facilities, but they cannot pay for the evidence from that State facility. We have been working with the States to try to figure out a better way of dealing with this. But it does become a problem because of State laws.

Mr. CAMPBELL. Do not a lot of those States in the State facilities have on line some psychiatrists from foreign nations that have not been certified in this country working, because they can work there without certification?

Ms. OWENS. I do not know that. I have heard that.

Mr. CAMPBELL. I wonder. I think that is probably true.

Mr. THOMAS. Will the gentleman yield?

Mr. CAMPBELL. Sure.

Mr. THOMAS. Can the doctors with a subspecialty in psychiatry—are they willing to do these diagnoses?

Mr. SIMMONS. I do not think we have had a significant problem in the past with respect to any of the medical consultants who work for us doing almost any kind of a case.

Mr. THOMAS. Doing almost?

Mr. SIMMONS. Doing almost any kind of case.

Mr. THOMAS. So no matter what their specialty or expertise, they have had no problems doing anything you have asked them?

Ms. OWENS. I would not say it exactly quite that way.

Mr. THOMAS. I did not think you would.

Ms. OWENS. We do have training courses in the application of the disability standards, so that a doctor with a subspecialty in psychiatry would have had some training on the adjudication of psychiatric cases. So there is more than just going in and adjudicating the case.

Mr. THOMAS. Has there been emphasis on the medical professionals in that profession? I think they are called QMRP's?

Mr. SIMMONS. Not that I am aware of.

Mr. THOMAS. It is my understanding they deal in a specialty area, and of course are not medical doctors, but both the AMA and the psychiatric association approve of this kind of a practice. And rather than taking a doctor who has a subspecialty or has to take a training in it, I am wondering if there has not been some investigation in those folks, who are not really paramedicals but are professionals in a narrow field?

Has there been any examination of this?

Ms. OWENS. I am sorry, I am not familiar with that term.

Mr. SIMMONS. In our general review of the standards and procedures we use, that certainly is a legitimate question for the work groups to take up.

Mr. THOMAS. They are qualified mental retardation personnel and they are professionals and they are certified in terms of doing a relatively narrow scope analysis in terms of mental impairment.

Ms. OWENS. We will certainly look into that.

Mr. THOMAS. If no one has looked into it, they really ought to.

Ms. OWENS. The mental retardation cases are not the most difficult ones to adjudicate, because that is one kind of case where there is some objective testing and accepted evidence in the forms of testing, and the requirements have to do with certain levels of IQ, and it is relatively easy to get the testing.

Mr. THOMAS. I would not want this area to bog down for lack of medical or psychiatrists or psychologists. There may be some professionals out there who are narrowly technically trained, who might be able to help.

I thank the gentleman.

Mr. CAMPBELL. I would like to tag onto that and then go back to my point. The review they have is actually protecting the right of a person to have this type of psychiatric review when they are disqualified. In order to qualify them initially, do you take the position it is not a necessary step?

Mr. SIMMONS. Because there are many cases where you can almost automatically qualify them. Even a layman could do it by looking at the record, although we want to have a medical decision made in every case.

But if we are put in the position where we have to have a certain specialty for every single one of these cases, we will be wasting a lot of work.

Mr. CAMPBELL. So you are taking the position that that will delay the qualifications?

Mr. SIMMONS. It could delay it. You would have some cases where you would have to shift the entire caseload out of State.

Mr. CAMPBELL. So that person would go through a period of time where they might have been declared eligible, but if they were not qualified then they would have the right to see a qualified professional. What you would agree to, what the Social Security Committee has tentatively agreed to, is to go then to a psychiatrist?

Mr. SIMMONS. In those cases you would have a psychiatrist taking a look at it. Let us say the medical doctor reviews the file and says, "I do not think this person is eligible." Then in that case it would go back to the psychiatrist for a decision first, before you even talked to——

Mr. CAMPBELL. You would have an automatic right to go to the psychiatrist? Not an appeal; it would be automatic?

Mr. SIMMONS. Yes; it would be automatic. It would be a bureaucratic device, but it would save a lot of psychiatric hours, which we do not have too much of out there.

Mr. CAMPBELL. Thank you.

Chairman FORD. The Chair will recognize Mr. Stark.

Mr. STARK. Mr. Simmons, in 1980 this subcommittee recommended, and it was enacted, the special program for SSI recipients in section 1619 (a) and (b). And you testified this morning about that

program, and I gather you have recommended it not be made permanent.

In looking through your testimony, one of the reasons for your opposition is that fewer than 300 cases in any month have become eligible, and you question its effectiveness.

Can you just outline very briefly for me what kind of outreach you did to generally make the public aware of this program, the specific training you gave to your caseworkers in terms of letting them know about the program, and approximately when you made this information available to the public?

Mr. SIMMONS. The very first information that went out to the public was about 30 days after the bill was signed, in the form of booklets reviewing the new amendments, the 1980 amendments, what they meant and all of that.

Mr. STARK. Do you have a copy of those booklets here?

Mr. SIMMONS. Yes; I do. I will submit them to you. This is the 1980 document.

Mr. STARK. This went out in 1981?

Mr. SIMMONS. July 1980, right after the bill was signed.

And in the process of a normal——

Mr. STARK. How many of these were printed?

Mr. SIMMONS. We produced about $2.5 million of these. That is a standard distribution to our district offices. We have 1,350 full-time offices and 4,000 part-time offices, and our people use this in the normal dealing with people. It is the easiest way to get things in one place.

When a person applies for SSI he is told that if he goes back to work he may be able to get benefits like this, and the States are certainly aware of it, and we relate to them and give them all of these materials. It goes out, and we have many, many ways of getting things out of our district offices, for example.

Mr. STARK. Do those go out usually in packets?

Mr. SIMMONS. They do.

Mr. STARK. Was there any specific training of the interviewers?

Mr. SIMMONS. The same month that pamphlet went out, for example, we have a mailing list of about 5,000, primarily advocacy groups, including groups that would be relating to this population, and they all received material on the amendments.

When a person applies for SSI he is told about these provisions. When a person begins work and would be in danger of losing his benefits, there is an automatic notification to the person that he will not lose his benefits. He never misses a check. That should happen automatically.

Mr. STARK. We have a good deal of testimony that there was no training of the people in the field offices who interview people coming in, to define for them the application process for 1619 (a) and (b).

In the 1982 edition of your SSI pamphlet, you make no mention of this program. You did mention it in your July 1983 brochure, but this just hit the newsstands, so to speak. These are the bulletins that get more distribution to the public, it seems to me, than your now out-of-print 1981 pamphlet [indicating].

And I question whether, in view of the fact that there was no training of the interviewers—these are the people who meet poten-

tial recipients—that the section 1619 (a) and (b) programs were at all publicized.

Mr. SIMMONS. They were trained in the context of the entire training on the 1980 amendments. This was one provision of the 1980 amendments. There were a whole bunch of provisions.

Mr. STARK. Did you review the testimony of our open hearings?

Mr. SIMMONS. I have not, sir.

Mr. STARK. I think you will find your employees testified time and time again that they would receive stacks of memos, but no training. Nobody sat down and no one listened to their suggestion that you perhaps have separate interviewers for interviewing disabled people and people coming in for retirement benefits.

It would seem to me—and I ask this not in a pejorative sense, but have any of your executives to your knowledge been through a mental illness process or had psychiatric or psychological help?

I have not had, but many of my constituents think I should.

I suspect not, and I suspect that you and I have no concept of the scariness of saying, you have got to go to a psychiatrist and then prove you are crazy. I mean, it would seem to be you are unstable enough going in.

I think the evidence is that we really have not educated people to understand this program. If you read the outline of the program that was finally printed, I would submit you have got to read it twice to figure out what you are talking about. I think that when you consider that we are dealing with people who are unstable or very scared or maybe very fragile, that we need a special kind of outreach.

The point I am making is that it isn't fair to say the program is ineffective when you have made no special outreach to the disabled and have not educated your workers about the program.

Unfortunately, I think the history has been, not only under this administration but under previous Republican and Democratic administrations, that where there is a provision this committee has written into the law that is not liked, it often gets half-hearted attention. And it is something we cannot do anything about in law, but I do not think it is valid to then say it is not effective unless you can point to the outreach with some pride and show that it did not work.

Mr. SIMMONS. When we redetermine a person's eligibility, we have to have accounting systems and all of this to make sure the person is still eligible. At that point the person can be reminded and probably is reminded of the existence of these provisions, in case he or she does go to work.

When the person shows earnings, when the earnings show up at the SGA level, he is told then. That is an internal identifying process. But if a person goes back to work, the money will show up one way or another, and at that point the person's eligibility is in jeopardy, but we automatically continue it.

It is a constant problem in any entitlement program to find out who the population is you want to reach and at what time you reach them. In this particular population, you do not have that many people going off for reasons of going to work. So when a person is contemplating that, they are more likely to talk to us, get

in touch with our office, at which point they are reminded this is available.

When they apply to the program they are told: This is available to you. If you ever go back to work, you may be able to keep your benefits for a while until you reach a certain income level.

But it is a constant problem. We can do a better job on training generally around the country. I think the agency for a long time neglected training because of the size of the workloads and because our data processing system is so bad that some things have been put off. We say, well, we have just got to cope with this thing, here is how you do it, you punch this button, and that is all you can do. You have just got to keep up with the workloads.

I think when our new system is in place it will be easier to build a lot of internal audits into our system that will identify people better.

Mr. STARK. What was the purpose, the overall management objective of the recent wholesale cancellation of disability recipients?

Mr. SIMMONS. The broad-range objective was to respond to the criticisms that grew in the early to late seventies, that pointed out that, while the incidence of disability in the economy was not changing much, this program doubled its incidence. Congress was very concerned, the Carter administration was concerned, and I daresay the Ford administration was concerned about the phenomenal growth in caseloads.

Mr. STARK. So basically, it was to reduce the caseload?

Mr. SIMMONS. It was to review the caseloads. The 1980 amendments were to go through the caseloads and see if it was true that x percentage of those people were not eligible and should not have been on in the first place.

Mr. STARK. It was to say they were ineligible and make them come back and prove that they were entitled to benefits.

Mr. SIMMONS. It is like any entitlement program. You always prove eligibility. It cannot be like in a criminal proceeding, where innocence is presumed.

Mr. STARK. Is it not a fact that your employees were motivated, given the thrust of that program and in fact rewarded in whatever modest way we public servants can be rewarded for reducing the caseload. In effect, reducing the caseload has become synonymous with success.

Mr. SIMMONS. I do not think that is an accurate characterization of it.

Mr. STARK. I think we will hear testimony later that will show that is the case.

I think it has been clearly documented, certainly in our field hearings, and will be further in the testimony today, that there are pressures and incentives to throw people off the roles. I recently got a letter from a staff attorney in the Office of Hearings and Appeals of SSA, and he said there is widespread falsifying of monthly production reports in order to inflate the case account and increase the bonuses for senior executive personnel at the Office of Hearings and Appeals. He claimed offices backdated disability hearing decisions, issued in October in order to fatten the September case count, thereby cheating the claimants out of part of their 60-day statutory right to appeal the denial of benefits.

He wrote it is also common practice in months when OHA has met its case quota and has excess decisions to mail them during the following lean month. As a result, claimants are kept waiting to hear the decisions of immense consequence to their lives. To cope with a quota system established by SSI and because productivity is defined in terms of speed and not quality, thousands of claimants do not receive fair consideration.

Now, it is very hard to write into law, ways to make the appeals process more responsive to the people's needs than to just dictate speedy procedures. I recognize and I know the committee recognizes that one needs to be efficient. But when the end result is taking the poorest of the poor and the most fragile and unprotected members of our society off the disability roles, it seems to me that that is a very harsh standard and way of measuring success.

Mr. SIMMONS. I agree with every single word you just said, but I do not agree that that letter accurately portrays what is going on in our agency. If someone has allegations of gaming in the system such as that, I would certainly like to have them.

Mr. STARK. I will make it part of the record. I have a hunch this is a matter of some discussion, because I think it is a union issue and I am sure they advocate the employees' position, and management obviously will, in asserting its own position, have some disagreement. But I think it would be interesting to hear.

I have no further questions, Mr. Chairman. But I think that in the committee's deliberation we have to be the advocate for making you somewhat less efficient in your purely managerial duties. Maybe we will serve as an excuse and thereby you can say the reason you and your team will not get the asphalt cookie of management efficiency of the month is because those people on the House committee mandated that you take care of some of the very poor people and the most fragile people in our society.

Having given you the excuse to dump that blame all on us, I hope that you will work with us. We will be the whipping people, how is that?

Mr. SIMMONS. I do not think anyone should look at a humane, fair, and effective program as being a matter to blame anyone for, sir. As I say, I agree with your points. I think that the reforms implemented last year, the reforms we are doing this year, plus some legislation to give us a definitive standard of medical improvement, to get that matter out of the courts, together will all go very far toward making this program what it should have been.

You must understand that when we inherited this review program, we didn't change a single procedure, not a single procedure. We just did it on a mass scale, and all of the defects of 26 years showed up immediately in horror stories that landed on your desk, our desk, and the front pages of the newspapers, and it should be pointed out——

Mr. STARK. But the point is, we go selectively.

Just one final question. How many people do you think are cheats in the disability program? What is the average way or the most common way for a person to cheat?

Mr. SIMMONS. The most common way would be to be working under the table, under the counter, as they say, without reporting

earnings or counting on the system not being able to catch up to his earnings for 2 or 3 years, because we are chronically behind.

Mr. STARK. Basically, I was going to agree with you. The only way I have heard that anyone can cheat the system is to go out and get a job, work.

Mr. SIMMONS. Or use someone else's social security number.

Mr. STARK. In America today is there any way you can conceive of as a practical matter that someone can cheat unless there are some people conspiring with them? For example, an employer who is not reporting under the social security system or paying in cash.

Mr. SIMMONS. You could have that, or you could use your son's number or something.

Mr. STARK. Then you have got another person in this.

Mr. SIMMONS. Not necessarily with that person's knowledge. There are ways to get around reporting wages.

Mr. STARK. What you are saying is, we are not being cheated by the standard, the idea of a slothful, lazy person who stays home and does not want to work. We are being ripped off by the brightest of the bright who figured out how to beat our complex system.

Mr. SIMMONS. But as a taxpayer and legislator, you are being ripped off by the person who does recover and does not report and just does not want to go to work. One of the tragedies of this whole review program——

Mr. STARK. But we have not seen much incidence of this and I have had no testimony of a significant number of lazy people. Quite the contrary, the testimony has been there are not many at all of those people who have been found to be cheating the system.

Almost the only evidence we have been able to find of cheats of any significant number are people who are working, and I submit that is not the common public perception and it is not the one fostered by this administration. Those people, if they were more highly paid, would be doing white collar crime and just cheating on the Internal Revenue Service. These are the middle-class brilliant, creative tax shelter folks who have found a way to work.

And I would submit that the concept that there are lazy people out there cheating the system just is not true. It is just that they are brighter than the people administering the system and they found a way around it, and that is often true of any laws you pass. The guys who get away with it extensively are constantly a step ahead of the administrators.

But we are going after the wrong folks. We should be going after the employer every time we find a cheat and putting him in jail for a while. And you might find if the penalty for hiring occasional household help without reporting social security withholding was severe, your problem of enforcing the law might disappear.

But we do not. We tend to blame it on people who stay home. I think you are focusing in the wrong direction by your own testimony. We see no figures from your offices that there is any substantial amount of cheating in this program, except by people who work.

Mr. SIMMONS. If you assume the law is correct and the definition is right, that the definition of disability should apply only to those people who are unable to do any job in the economy, and you find a person able to do a job in the economy sitting at home, having re-

covered, or their condition was never that bad in the first place, but that person got on the rolls 10 years ago at a time when the program was swamped, is that person not in effect cheating the taxpayers?

Mr. STARK. Perhaps as we presently define disability. However, a person may be able to lift 20 pounds, but unable to perform a job because of an employer's unwillingness to hire anyone who is known to have been disabled. As a result these people are functionally unable to work.

It seems to me that our society as a whole has to deal with this problem. It may not be just your agency, but we cannot ignore it. We keep pushing this problem one way or the other, but it will not go away.

Mr. SIMMONS. One of the tragedies of this review procedure is some people have been on those rolls 8 or 10 years, getting a check every month saying, "your Government says you are disabled, here is another check." And suddenly, never having been told they are going to be looked at, suddenly they are brought in and you look at this person saying, you got on there with what you called a bad back and a herniated disc, and now that is all cured. You have had surgery, so you have got to go to work.

They are disabled in their minds. They have been out for 10 years. They do not know about getting up and going to work and all of that. That is one of the reasons for some of the horror stories. You have seen people who have become emotionally disabled because of a physical disability.

Mr. STARK. I would not agree with you more, but the question comes down, can we abdicate that responsibility? As long as we have it—as long as we know where they are, who they are, would it not properly be more efficient to allow you to direct them into some training or to continue to support them, rather than shove that cost over to another agency where we as taxpayers will end up paying for it?

Maybe we ought to have a quasi-qualification. It seems to me the gap between say 51½ and 65 is just at the point where you are in never-never land. You are discriminated against just because you are older, and an employer just instinctively will move to the younger employee.

So you recover from a stroke for example, and then what do you do? You are 58 and you say, I have had a stroke. The employer says, geez, I am sorry, I have got another interview in 5 minutes.

I am not suggesting that your agency causes this. But I am suggesting that we should expand our scope to find that group—and I think we are both talking about these people who fall through the definitional cracks. They do not go away. They are there and they come back to us, and probably as more expensive cases than if we could somehow maintain them in a comfortable environment without being so extravagant as to be criticized for giving them a lifestyle without working.

Thank you for your testimony and cooperation. I hope we can work together to broaden and make the disability program more flexible. I also hope we can give the people in the field more opportunity to make decisions in the field, at the field level, and deal

with the cases as they see them across the desk or in the interview room.

I think that somehow I have a great deal of confidence in the employees you have out there, if we could somehow find a way to let them make more initial decisions at the interview level.

Mr. SIMMONS. Part of what Ms. Owens' office has been doing is bringing in groups of State and Federal field employees to sit down on that very issue and say, what can we do to give you latitude without longitude, on having more discretion in the case, cutting off the case review at a point where it is obvious we should not be reviewing this case?

We started that with face-to-face interviews in our own offices a year ago, and it is working out well. Three to five percent of the people who come in the door to be seen by our own people—not even that well trained in disability, they are not disability specialists—they look at the person and take their history and say, "you are right, get out of here, your case doesn't need to be reviewed."

We are trying to extend that principle more to the State agencies, who are looking mostly at paper, to give them more discretion in that same area, to find those obvious cases that will end up as the horror stories and should never be reviewed in the first place. But is a long process.

The agency has not had a long history of reaching out to State agencies, and some of the State agencies have been very helpful. We had one whole day in Denver where we did nothing but brainstorm with State officials on this subject.

Mr. STARK. As a further step toward a conciliatory gesture, the remark I made some months ago relating to a canine——

Mr. SIMMONS. I recall seeing a response to that.

Mr. STARK [continuing]. And a fish was directed to Mr. Swoop and not the present witness.

Mr. SIMMONS. He will be glad to hear that, sir. [Laughter.]

Chairman FORD. Mr. Matsui.

Mr. MATSUI. Mr. Simmons, I tend to agree with some of the factual statements made by Mr. Stark in terms of the publicity given to the so-called experimental program of 1619 (a) and (b). In your 1982 brochure on SSI, you devote page 20 and 21, two full pages, to the entire procedure and what occurred when a beneficiary returns to work. You talk about the continuation of medicare benefits for 3 years and the fact that payments will continue, and also what happens if a former recipient becomes disabled again.

And it seems to me in your latest document describing SSI in July of this year, you really downplay this program by devoting only one paragraph to describing it.

Mr. SIMMONS. The booklet on your left hand, sir, is the combined program booklet. This primarily focuses on the title II disability program. The other covers just the SSI program.

Mr. MATSUI. Yes; this one. But this booklet has very little discussion on the 1619 program. It seems that this pamphlet is not in print any more. These superseded it.

Mr. SIMMONS. That one on supplemental security income. The other one has been superseded by a later one in the same area. But this is a general disability brochure.

Mr. MATSUI. So this pamphlet is still given out, is it not?

Mr. SIMMONS. Or some version of it.

Mr. MATSUI. This is August of 1982, and it has the same information in it?

Mr. SIMMONS. Yes. That has been updated since the other was published.

[Pause.]

Mr. SIMMONS. We have many, many ways of communicating besides those pamphlets. Those offer the convenience for people who follow up with an idle question or something. When people come in to see our people, they should get more information orally and in the nature of forms they fill out to apply for certain things.

We also relate very heavily once a month to this mailing list of 5,000-odd groups. We send them continually changing materials that emphasize what benefits are available and all of this. These people, in turn, are very effective in going out and finding their constituency and telling them about benefits that are available to them.

I have been in welfare administration off and on for 14 years, and I think the fastest way to get word around to the clientele that you really want to hit in the language they really need to hear is through the advocacy groups and through the normal grapevine that operates out there in the community.

I do not think anyone who will be entitled to that will not know about it. They are reminded of it when they come in for a redetermination. It is in the literature. It is in the handbook that they have at home that everybody receives. How much is enough I do not know, but I think as public information programs go, social security has historically done a good job, and we have had to fight off the budget cutters every time they look at the budget.

The amount of money we spent on pamphlets and communications for our population, keeping in mind much of our population is very old and disabled and that we have a very tough time communicating with them, and it is a very big program—but we have managed to stave off the budget cutters on that issue, and I think we do a remarkable job. I really do.

You can always say, well, you could write it differently. We have had consultants in to talk about language and all of that.

Mr. MATSUI. You see, many of the groups concerned about the disabled indicate that the notification has not been done properly and that many people do not know about these programs. As Mr. Stark says, the training process has not been very good.

Mr. SIMMONS. Well, training is a continuing problem. We are doing better on training, but this is a law that has created enormously complicated programs. It has 47 volumes of legislative history. To train a claims representative today is an incredible process. It is a 13-week course to get someone to understand just the basic things. We do separate interviews for the disabled, for the SSI programs.

Mr. MATSUI. I think you will find many of the groups who appear after you will testify that the notification process has not been good, and that many of the disabled individuals are not aware of the consequences of going back to work. I think you will hear that testimony.

The point I am trying to make, however, is that while you might be doing a good job, the question is whether we should continue this program and whether the fact that only 300 people have utilized it on every month is a fair test of its effectiveness. I think that is really the issue. If it is a fair test, then maybe we should cancel the program. But if it is not a fair test, then obviously we should give it more time; and I think that is the issue before us right now.

Mr. SIMMONS. If the Congress is to give us more time, we would prefer to see it with a research component somewhere built in.

Mr. MATSUI. I was going to go into that as my next question. That would be the next question.

You indicate there is a potential substantial loss in 1988 of $35 million in Federal expenditures and $29.5——

Mr. SIMMONS. It would be a 5-year total.

Mr. MATSUI. But you are basing it on the 300 per month figure that go into the program, is that right?

Mr. SIMMONS. We do know there are 5,600 who are on the medical only part.

Mr. MATSUI. But how many of those individuals would have stayed off had this program not existed?

Mr. SIMMONS. That we do not know. We do not have data. I am sorry to say we do not.

Mr. MATSUI. So your figures could be mistaken based upon the worst case scenario, is this correct? That everyone would have gone to work whether this program existed or not.

Mr. SIMMONS. Right.

Mr. MATSUI. So, frankly, it could be a zero loss of face and Federal expenditures.

Mr. SIMMONS. No; it cannot be. It would not be. Let me ask Mr. Smith to address the numbers again.

Mr. MATSUI. Let me just say this. Perhaps he can give us this information, because I think we do want to continue. I do wish that when you provide us with the documentation and numbers that you do state the conditions upon which they are based. It would make it easier for us. Then we will not have to involve ourselves in these questions and try to embarrass you or embarrass ourselves with it. You may just say these figures may not be accurate because we do not have data to justify them.

I think we can say gee, that is great, you are at least being candid with us, and we know where everybody stands. But instead, we read this, and we have to figure out for ourselves what they are based upon. I just think we need better information.

Mr. SMITH. I want to be sure the committee gets as much as we can give you on the background and the actuaries' thinking. The actuaries tell us that is as good an estimate as they can give us right now based upon the information we have. It will be in that ballpark. It has to be because of the number of people you know are there and anticipate moving on.

Mr. MATSUI. Thank you.

I have no further questions, Mr. Chairman.

[Information regarding actuaries estimates, and assumptions underlying those estimates follows:]

EXTENSION OF 1619 (a) AND (b)

Information collected by the Social Security Administration is that 5,594 individuals in December 1982 retained Medicaid eligibility after losing SSI cash benefits because their earning exceeded the SSI income limitations. This is the only piece of program data regarding 1619(b) which is available.

All actuarial calculations must necessarily depart from this single piece of information by building in a variety of assumptions, such as those about how many job opportunities are available or will become available to disabled individuals, the prevalence and type of private, employment-related health insurance for disabled individuals who work, the ages and residual work skills of the disabled individuals, and the response of disabled individuals to incentives contained in section 1619(b). Because of the limited base of actual data, cost estimates are by their nature subject to substantial variations and are considered an actuarial opinion rather than a precise actuarial estimate. The actuarial opinion could, of course, change when more is known about the section 1619(b) Medicaid recipient population.

The estimate of $36 million in Federal costs and $30 million in State costs originally developed was an estimate of the total expense over the next 5 years of the Medicaid costs of all those individuals who would continue to be eligible under section 1619(b) if section 1619(b) became a permanent part of the law beginning January 1, 1984.

At the other end of the range, the actuaries estimate that if section 1619(b) were eliminated, the Federal costs could be $9 million and State costs could be $7 million for a total of $16 million over 5 years if similar assumptions are made about the number of individuals who would lose their Medicaid eligibility due to taking work. These costs would be attributable to the assumption that 2,700 out of an expected 10,900 recipients would lose their Medicaid eligibility were section 1619(b) eliminated.

The Actuaries believe that the average effect of eliminating section 1619(b) over the 5-year projection period would be that 8,200 out of 10,900 recipients would retain their Medicaid eligibility by opting to leave work and stay on the SSI rolls. Additional SSI cash benefits costs would be incurred for those people who would opt to stay on the SSI rolls as well as additional costs for other programs such as food stamps.

In both instances the estimates reflect only Medicaid costs—any effect that the program might have on SSI or other costs was not included.

These costs would be considerably lower in both instances if we were to permit time-limited Medicaid coverage of 2 years after the end of a trial work period rather than an indefinite continuation of Medicaid coverage.

Chairman FORD. Mrs. Kennelly.

Mrs. KENNELLY. Thank you, Mr. Chairman.

I would just like for the record to express my concern about the problem we have in getting the information out. I am from an urban center where we have advocates for the individuals we are talking about today, and the advocates do not seem to know there is a program. And the people, because of situations of fiscal restraint in the State, are on the streets. I think that is why we are here today, to bring everybody together.

But one particular question, sir, on page 9, part of your testimony, on the bottom of the page you start about your top to bottom review. You say:

> One of our policies and procedures is examining whether a medical improvement requirement for terminating disability benefits should be adopted.

You are thinking about a medical improvement requirement. Could you tell us what kind of requirement had been used before?

Mr. SIMMONS. Except for a 6-year period beginning around 1969, the program had always just taken the definition of the law that said you must be so disabled that you cannot do anything anywhere in the economy, period. And you look at the person in light of that. That is the standard for whether a person should be al-

lowed onto the rolls, and it is the standard by which a person should be allowed to stay on the rolls.

For a 6-year period in the early 1970's there was a medical improvement rule based upon some administrative law judge's decision which we then wrote into regulations. The States unanimously asked us to scrap it because they could not administer it, it was so difficult.

The big issue with medical improvement is it is very difficult to come up with a definition that is not so full of loopholes that people can slip through and stay on, and then you create two classes of people, some with the same conditions today who cannot get on, but some with that same condition who are on because they were on before.

So we are trying to work with the Pickle subcommittee, and this afternoon that is one of the final issues I believe they will take up, on how to refine the medical improvement standard they have proposed in such a way that it takes into account advances in medical technology and advances in the general medical community's understanding of what is disabling and what is not.

Ten years ago, one heart attack and you were gone from the work force for the rest of your life, and nowadays you are back to work in 6 weeks. How do you differentiate? How do you come up with a medical improvement standard that does not allow a person who had a relatively minor infarction incident 10 years ago to get a free ride through the system for the rest of his life when someone coming in today is not eligible?

It is a difficult moral question. We are hoping we can put it in the law as opposed to doing it administratively, should we decide to do it, as there will be much less litigation over it if it is in the law. If we do it by regulation, someone will have a different idea. And we have already got eight or nine courts around the country giving us different medical improvement standards. Some conflict; some do not make any sense. So it is obvious the courts are moving in this direction and the Congress is obviously doing so, also.

Mrs. KENNELLY. Let me get this clear. You will have a top to bottom review?

Mr. SIMMONS. For all policies.

Mrs. KENNELLY. But let me get a handle on the factors you will use for this medical improvement test.

Mr. SIMMONS. On medical improvement the issue we are looking at is, as I said, how do you come up with one that does not leave somebody on the rolls, and have somebody who comes in today with the exact same condition not be able to get onto the rolls. That is the problem, unless you are going to grandfather a certain number of people.

Mrs. KENNELLY. It would seem to me that those on the rolls you would just have to see if he has improved enough to get off the rolls. You cannot do it at the same time, can you?

Mr. SIMMONS. But some of those people who came on are on for conditions that better diagnoses today would say they did not have, or better technology today, or drugs that have been invented since then, or treatment therapies that have made a difference in that person's life or potentially made a difference in that person's life or our understanding of the disability.

I used the example of a heart attack. If you have a standard that allows that person to stay on but does not allow a new person with the same condition on, then you have created an awful inequity in the program.

Mrs. KENNELLY. I am afraid I am hearing in the testimony that there will be too much emphasis on worrying about that person who is on there without worrying about the person who maybe should be on there.

Life is not fair. You have heard that before. We have got to use new factors as well as old factors to make sure we are being fair. And somehow I hear the emphasis—and Mr. Stark brought it out—you cannot rewrite history. You have these cases. But at the same time you review these cases. When you feel there is something going wrong, you have got to keep a positive attitude about the new cases.

Mr. SIMMONS. I think the bigger question you are raising is should we grandfather a significant number of people automatically.

Mrs. KENNELLY. I think that is going to be an administrative question that we all must look at, but it is an administrative decision to make where the emphasis goes, worrying about those who might be getting away with something, and God help those who might need to get on.

Ms. OWENS. In reviewing our policies and procedures we are not just reviewing the policies and procedures that relate to continuing disability. We are also reviewing all of the standards of entitlement for new entitlements, too, so that we are getting at the issues you address.

The way this is framed in the statement talks primarily about the continuing disability and medical improvement, but the top to bottom review does include all policies and procedures.

Mrs. KENNELLY. Thank you.

Mr. MATSUI. Mr. Chairman, may I have just one question?

Chairman FORD. I want to pick up on new entitlements.

What happens at the initial level with your claims representatives with the claimants? Are they making recommendations or decisions—not decisions but recommendations one way or the other to go on to the State agencies?

Mr. SIMMONS. They look at the nonmedical factors like, do you have quarters of coverage or the right income levels in an SSI case and all of that. They make observations in the process of helping the person fill out the form. They will note any apparent physical evidence, for example, if a person were observed to have a pronounced limp and that kind of thing. But that is just anecdotal material to send to the State agency where the real medical work is done.

Chairman FORD. Do you find that there are times that the clerk or the claimant representative may send a person out of the office?

Mr. SIMMONS. What I was speaking of there, in the continuing investigation cases where you are calling in people who have been on the rolls, who will be reviewed under the 1980 amendments, in those cases the process used to be based only on a letter, and then they were supposed to send a letter to the State agency, and we never got into it in a face-to-face way.

Chairman FORD. The claims representatives are not making decisions or recommendations one way or the other.

Mr. SIMMONS. No. The only decision they are making is if they get a person in who so obviously should not be reviewed—some people, for instance, are bed-bound somewhere. We do not even know that until we send them a notice, and we find out they cannot come in, and we send a person out to their house. And if the person is obviously disabled, he or she should not even be reviewed, it should be a classification of disability permanent. Then our person sends the folder back to Baltimore and says here, this one should not be looked at.

Chairman FORD. Should or should not?

Mr. SIMMONS. Should not be looked at. Do not even look at this person. He should stay on the rolls. Do not review him. It is not worth it.

By that process we pick up 3 to 5 percent of those called in for interviews, and right on the spot we are stopping reviews.

Chairman FORD. What about new entitlements, though?

Mr. SIMMONS. On new entitlements the district office does the nonphysical workups, and the State agencies go through all the medical evidence.

Chairman FORD. And when they forward it on to the State agency, are there recommendations?

Ms. OWENS. They do not actually make recommendations as to whether or not the person is entitled, because that is a medical decision. You have got to develop medical evidence. But in some of the large offices now we are experimenting with having a DDS consultant, a person from the State disability determination service, there on site in the district office to help go through the interview and note certain of the characteristics of that person.

Chairman FORD. In other words, nothing favorable, but some unfavorable comments.

Ms. OWENS. No. I may have misrepresented the process. What I am trying to say is the claims representative who takes the claim cannot make a decision as to whether the person is entitled. It takes medical evidence to do that. And the State agencies do that.

Chairman FORD. But do they comment one way or the other?

Ms. OWENS. They make observations about how the person portrays himself, how physically the person looks, and that can be very important to the State agency person in making a decision. If they know a person looks a certain way, that can be used as a factor to be developed.

Chairman FORD. So it is up to that claim representative to make those comments one way or the other based upon the way the person looked and——

Ms. OWENS. Or how they walk or breathe. That could be another example.

Chairman FORD. So you have got to act like you are disabled.

Mr. SIMMONS. That is true in any entitlement program. You have to act like you are poor or disabled or whatever to get on any program. We do not have the power or will to send investigators out to let the air out of somebody's tire to see if he can change it, the kind of thing private insurance companies do. We do not do that. We depend on objective medical evidence and a commonsense

view of the person, an informed view of the person who is coming in to apply to this system.

But what the social security employee sees in dealing with the person may have some bearing on the decision made by the State agency. Generally, if a person comes in and you had trouble getting the person to focus on the paper, that is all relevant. You make some notes saying what you think of this person. They may say, "This person looks like a bad case to me, and we ought to check it out".

Ms. DAVIS. I observed an interview, if I may, Mr. Chairman, a couple of weeks ago which exemplifies the kind of observation we ask a district office person to annotate. The claims representative interviewed a woman who had difficulty speaking and also had a heart condition. That claims representative noticed that in fact the lady had a very hoarse whisper and that during the course of the interview she required a medication to relieve her chest pains, and the claims rep noted that the stress of the interview appeared to require this lady to take her nitroglycerine.

That is a kind of observation a claims representative will put down.

Mr. SIMMONS. In some offices we are out-stationing State consultants to help us. Those people are highly trained, and we have had those in 60 or 70 of our major offices where most of the disability business is done, and I think that will prove to be a very effective way of dividing up the Federal-State responsibility and getting some faster action for some of these people who come in the door.

Chairman FORD. You do not have merit pay for your employees, do you?

Ms. OWENS. Not for claims representatives.

Chairman FORD. Mr. Matsui, did you have a question?

Mr. MATSUI. You covered what I wanted to ask, Mr. Chairman.

Chairman FORD. Thank you very much, Mr. Simmons. We appreciate your testimony and your responses to the questions. Thank you very much. The committee will look forward to receiving the submissions you have indicated.

The committee will call up the first panel. Mr. Robert Gorski, the editor of Disabled USA, Washington, D.C., a member of the President's Committee on Employment of the Handicapped; Ms. Ruth Phillips, Silver Spring, Md.; and Mr. Bill Malleris, Rochester Center for Independent Living, Rochester, Minn.

The committee would like to welcome all three members of the panel that will be testifying at this time before the Public Assistance Subcommittee. We are delighted to have you today. We are sorry you had to wait so long. Thank you very much for coming.

[The following was subsequently received:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., April 25, 1983.

Mr. ALLEN JENSEN,
Subcommittee on Public Assistance and Unemployment Compensation, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. JENSEN: In January of this year, we provided information on persons affected in May and August 1982 by the 1980 SSI work incentive provisions—Sections 1619(a) and 1619(b).

Similar data on these provisions are now available for December 1982, and as you requested, this material is being forwarded.

If you have any questions, please call Jack Schmulowitz (301-594-6595).

Sincerely,

RONALD L. DAVIS,
Acting Deputy Associate Commissioner,
Office of Policy.

Enclosure.

PERSONS AFFECTED IN DECEMBER 1982 BY THE 1980 SSI WORK INCENTIVE PROVISIONS—SECTIONS 1619(a) AND 1619(b)

This paper presents preliminary data for December 1982 on persons coded in the SSA data system as receiving SSI special cash benefits under Section 1619(a) and retaining Medicaid eligibility under Section 1619(b) of the Social Security Act. Similar data covering experience in May and August 1982 under these provisions of the 1980 Social Security Disability Amendments were previously made available.

SSI SPECIAL CASH BENEFITS—SECTION 1619(a)

The information on persons covered under Section 1619(a) discussed here is based on counts of people coded as eligible under that section in December 1982. We believe these data overstate the actual number of recipients affected by this provision because some of the people so coded no longer have any earnings. These people were at one time eligible only under 1619(a), but as of December were also eligible under the regular program.

Data for December 1982 show:

Coded cases with reported earnings	287
Coded cases without reported earnings	152
Total cases coded as covered under section 1619(a)	439

The records of the 152 recipients should have been redesignated to regular SSI payment status when their employment ceased.[1] In addition, 47 of the 287 employed recipients had monthly earnings below $300. This level of earnings may indicate that the recipient is no longer able to engage in substantial gainful activity and that many of these cases should be redesignated to regular SSI payment status also. Such a finding for some of these 47 cases may however, require field staff development.

In terms of SSI benefit payments, separating out recipients who have stopped working reduces expenditures attributed to 1619(a) by a higher proportion than it reduces recipient counts because persons without earnings are eligible for higher SSI payments. The December data indicate that the 287 employed 1619(a) persons, represented 65 percent of the coded cases but only received 48 percent of total SSI payments made to all 439 recipients (they accounted for 44 percent of Federal SSI payments and 60 percent of State supplement payments).

Benefit payments under Section 1619(a) during fiscal year 1982, based on payment codes alone, were $784,000 (Federal SSI—$554,000 and State supplementation—$230,000). For the first six months of fiscal year 1983 (October 1982-March 1983) payments were $606,000 (Federal SSI—$436,000 and State supplementation—$171,000).

Monthly figures for calendar year 1982 and the first quarter of 1983 based only on the Section 1619(a) payment code, indicate a good deal of variability in the caseload under this provision:

1982:	
January	307
February	372
March	476
April	370
May	321
June	511
July	484
August	595
September	506

[1] Redesignation which requires manual input by Social Security Administration field staff has been subject to a time lag.

October	387
November	424
December	439
1983:	
January	478
February	597
March	629

Table 1 presents data on the State distribution of persons under Sections 1619(a) and 1619(b). The average monthly earnings of the 287 recipients with SSI special cash benefits were $456 (table 2)—$459 for the 158 men and $453 for the 129 women. In terms of age, 8 percent of those employed were under 22, and 63 percent, between 22 and 39 years of age (table 3). Men comprised 55 percent of the total number of recipients.

RETENTION OF MEDICAID ELIGIBILITY—SECTION 1619(b)

In December 1982, Medicaid eligibility was being retained for nearly 5,600 former SSI recipients. Of these, 289 were blind and 5,305 disabled. Their average monthly earnings were $623 (blind—$802, disabled—$613)—table 4.

Ten percent of the persons under Section 1619(b) were under 22, and 63 percent between 22 and 39 years old. Fifty-five percent were men (table 5). The age and sex distributions are similar to those of the SSI recipients with earnings under Section 1619(a).

TABLE 1.—NUMBER OF PERSONS RECEIVING SSI SPECIAL CASH BENEFITS UNDER SECTION 1619(a), DECEMBER 1982 AND NUMBER OF PERSONS RETAINING MEDICAID ELIGIBILITY STATUS UNDER SECTION 1619(b), DECEMBER 1982, BY STATE

State	Cases coded as section 1619(a), December 1982		Retaining medicaid eligibility under section 1619(b)		
	Total	With earnings	Total	Blind	Disabled
Total	439	287	5,594	289	5,305
Alabama	3	3	70	8	62
Alaska			22	1	21
Arizona	6	5	47	5	42
Arkansas	3	3	46	4	42
California	120	72	771	29	742
Colorado	6	4	119	6	113
Connecticut	1	1	99	3	96
Delaware	2	1	17	1	16
District of Columbia	5	5	33	1	32
Florida	15	10	177	8	169
Georgia	3	1	122	9	113
Hawaii	2		41	1	40
Idaho			22	1	21
Illinois	16	14	266	14	252
Indiana	5	4	109	8	101
Iowa	6	5	64	3	61
Kansas	7	6	62	1	61
Kentucky	5	4	63	4	59
Louisiana	7	2	142	4	138
Maine	2	2	30	5	25
Maryland	3	1	111	5	106
Massachusetts	12	11	224	11	213
Michigan	10	4	150	13	137
Minnesota	5	4	159	3	156
Mississippi	4	2	45	5	40
Missouri	6	3	86	3	83
Montana	1	1	17	2	15
Nebraska	3	1	23	1	22
Nevada			34	1	33
New Hampshire	2	1	15	2	13
New Jersey	3	3	147	6	141

TABLE 1.—NUMBER OF PERSONS RECEIVING SSI SPECIAL CASH BENEFITS UNDER SECTION 1619(a), DECEMBER 1982 AND NUMBER OF PERSONS RETAINING MEDICAID ELIGIBILITY STATUS UNDER SECTION 1619(b), DECEMBER 1982, BY STATE—Continued

State	Cases coded as section 1619(a), December 1982		Retaining medicaid eligibility under section 1619(b)		
	Total	With earnings	Total	Blind	Disabled
New Mexico	1	.....	33	5	28
New York	53	33	587	17	570
North Carolina	4	3	90	7	83
North Dakota	1	1	9	.....	9
Ohio	17	9	227	14	213
Oklahoma	7	5	102	8	94
Oregon	3	1	74	6	68
Pennsylvania	21	13	212	9	203
Rhode Island	.....	.....	25	3	22
South Carolina	4	3	56	6	50
South Dakota	3	2	20	1	19
Tennessee	3	1	61	2	59
Texas	21	13	381	30	351
Utah	2	1	22	.....	22
Vermont	2	2	18	.....	18
Virginia	5	5	104	6	98
Washington	14	11	126	3	123
West Virginia	4	2	20	.....	20
Wisconsin	11	9	87	3	84
Wyoming	.....	.....	6	1	5
Northern Mariana Islands	.....	.....	1	.....	1

TABLE 2.—RECIPIENTS OF SSI SPECIAL CASH BENEFITS: NUMBER AND PERCENTAGE DISTRIBUTION BY EARNINGS, DECEMBER 1982

Monthly earnings	Number
Total with earnings—number	[1] [2] 287
Total with earnings—percent	100.0
Less than $100	2.1
$100 to $149	1.7
$150 to $199	2.4
$200 to $249	4.5
$250 to $299	5.6
$300 to $349	14.6
$350 to $399	11.8
$400 to $449	10.5
$450 to $499	10.1
$500 to $549	7.7
$550 to $599	8.7
$600 to $649	6.6
$650 to $699	4.2
$700 to $749	2.8
$750 to $799	1.0
$800 and over	5.6
Average earnings:	
Men	$459
Women	453
Total	456

[1] An additional 152 persons coded as coming under section 1619(a) did not have earnings in December 1982.
[2] Includes 158 men and 129 women.

TABLE 3.—PERSONS RECEIVING FEDERALLY ADMINISTERED SSI SPECIAL CASH BENEFITS: TOTAL AND NUMBER WITH EARNINGS AND PERCENTAGE DISTRIBUTION BY SEX, AGE, AND RACE, DECEMBER 1982

Age and race	Cases coded as section 1619(a)			Number with earnings		
	Total	Men	Women	Total	Men	Women
Total number	439	236	203	287	158	129
Total percent [1]	100.0	100.0	100.0	100.0	100.0	100.0
AGE						
Under 22	7.3	8.5	5.9	8.0	10.1	5.4
22 to 29	42.6	47.9	36.5	42.5	48.7	34.9
30 to 39	23.7	23.7	23.6	20.2	19.6	20.9
40 to 49	14.1	11.9	16.7	17.1	13.9	20.9
50 to 59	9.1	5.1	13.8	9.8	5.7	14.7
60 and over	3.2	3.0	3.4	2.4	1.9	3.1
RACE						
White	75.4	72.5	78.8	78.7	77.8	79.8
Black	15.5	16.1	14.8	13.6	12.7	14.7

[1] Other and unknown race included in total.

TABLE 4.—NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RETAINING MEDICAID ELIGIBILITY BY MONTHLY AMOUNT AND AVERAGE EARNINGS, DECEMBER 1982

Monthly earnings	Total	Blind	Disabled
Total number	[1] 5,515	286	5,229
Men	3,035	177	2,858
Women	2,479	109	2,370
Total percent	100.0	100.0	100.0
Less than $100	5.4	.4	5.7
$100 to $149	4.5	1.0	4.7
$150 to $199	6.7	2.8	6.9
$200 to $249	5.1	1.0	5.3
$250 to $299	4.6	3.5	4.7
$300 to $349	4.0	3.2	4.0
$350 to $399	2.4	1.4	2.4
$400 to $449	3.2	6.3	3.1
$450 to $499	3.0	6.6	2.8
$500 to $549	5.1	5.2	5.1
$550 to $599	4.7	5.9	4.6
$600 to $649	5.0	4.2	5.0
$650 to $699	5.2	4.2	5.3
$700 to $749	6.1	3.5	6.2
$750 to $799	5.1	4.2	5.1
$800 to $899	8.6	11.9	8.5
$900 to $999	5.7	7.3	5.6
$1,000 to $1,099	5.4	8.4	5.2
$1,100 to $1,199	2.8	4.2	2.7
$1,200 and over	7.5	14.7	7.1
Average earnings:			
Men	$646	$841	$634
Women	595	739	589
Total	623	802	613

[1] 79 persons who did not have earnings in December 1982 are excluded.

TABLE 5.—PERSONS RETAINING MEDICAID ELIGIBILITY: NUMBER AND PERCENTAGE DISTRIBUTION BY SEX, AGE AND RACE, DECEMBER 1982

Age and race	Total	Reason for eligibility		Sex	
		Blind	Disabled	Men	Women
Total number	5,594	289	5,305	3,078	2,515
Total percent [1]	100.0	100.0	100.0	100.0	100.0
AGE					
Under 22	10.0	11.1	9.9	12.3	7.2
22 to 29	41.4	47.1	41.1	45.7	36.2
30 to 39	22.0	18.7	22.2	21.0	23.3
40 to 49	11.7	10.7	11.8	9.6	14.3
50 to 59	10.1	8.0	10.2	7.9	12.8
60 and over	4.7	4.5	4.7	3.5	6.2
RACE					
White	72.6	68.9	72.8	72.9	72.2
Black	17.1	21.5	16.9	17.5	16.7

[1] "Other" and "unknown" races included in total.

Chairman FORD. We will recognize Mr. Gorski.

Mr. GORSKI. I am sure all three of us are very glad.

Chairman FORD. Would you give us the correct pronunciation of your name?

Mr. GORSKI. It is Robert Gorski.

Chairman FORD. Well, I had it almost right. Thank you.

The Chair recognizes you at this time.

STATEMENT OF ROBERT GORSKI, EDITOR, DISABLED USA, WASHINGTON, D.C., MEMBER, PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED

Mr. GORSKI. The opportunity to address the subcommittee this morning is particularly pleasing to me because I also testified before the subcommittee in 1979 when it considered legislation which ultimately became the Social Security Amendments of 1980.

Two of the 1980 law's most significant work incentive options for disabled recipients of supplemental security income, SSI, are due to expire in December. The first is section 1619(a) of the Social Security Act. This section established a special benefits program for SSI recipients whose earnings take them above the substantial gainful activity threshold.

The second important incentive option expiring in December is section 1619(b) which permits continued medicaid eligibility for many SSI recipients whose earnings place them in the special benefits category or end receipt of SSI benefits altogether.

Prior to passing the Social Security Amendments of 1980, both the 95th and 96th Congresses had studied how technical barriers inherent in the language of the Social Security Act was preventing disabled SSI recipients from attempting and maintaining employment, especially those recipients who strove to reduce their dependency on public assistance by performing substantial work despite a severe medical impairment.

As a result of the cooperative work of Congressmen, Senators, their staff, and disabled consumers and other people concerned

with disability, a very strong bipartisan support in both houses of Congress developed in support of work incentive options to the SSI program.

The work incentive options about which this panel and other witnesses this morning are testifying are particularly important for the more severely handicapped among SSI recipients. Experience in recent years has shown that the perponderant majority of all disabled persons want to work and support themselves financially as much as they are able.

Given appropriate training and education, practical aids and equipment, and appropriate work site and supervisorial circumstances, almost any disabled person can successfully perform some productive activity. In some cases the circumstances of disability might limit the disabled person's productive activity to intermittent employment or periodic employment. In some cases, disability-related expenses that an individual has may equal a large part or even exceed the remuneration obtained from employment.

Nevertheless, disabled people and those persons concerned with disability agree that the concept of classifying some disabled individuals as totally incapable of productive activity is no longer valid. Instead, programs like SSI and medicaid must recognize that recipients must be allowed to explore work opportunities. To do this requires permitting disabled persons to mix earnings from employment with Federal cash assistance and medical benefits and gradually reduce dependency on Federal programs. In this way a disabled person can effectively test his or her capability for employment without endangering his or her health and well-being by an abrupt cessation of cash and medical assistance.

From the report from the Social Security Administration it may appear that section 1619(a) and 1619(b) are not being greatly utilized. According to the figures made available, a few hundred disabled persons were in the special benefits program established by section 1619(a). Also, over 5,000 disabled persons were eligible for medicaid under the terms established by section 1619(b).

These figures should not be taken to indicate that the two work incentive options are not an appropriate solution to the problem they are supposed to address. Instead, the figures reflect the level of dissemination of information about the changes instituted in the 1980 legislation.

Getting information out to the disabled community is no simple task. It requires the best efforts of the Social Security Administration and the cooperative efforts of disability organizations, rehabilitation agencies, and other groups concerned with disability.

In the future, efforts to alert and explain work incentive options to disabled SSI recipients should build on past successes.

Soon after the 1980 legislation became effective, the Social Security Administration published a small brochure which I have labeled exhibit A in my testimony, which did a sound job of explaining the work incentive options created by the 1980 legislation. However, that brochure is no longer available. It has been superseded by a series of SSI pamphlets issued quarterly. See exhibit B to my testimony for an example of the July 1983 edition.

This recent series of pamphlets gives little attention to the work incentive options created by the 1980 legislation. The Social Secu-

rity Administration also produced a fine booklet designed to explain work incentive options to professionals in the field of vocational rehabilitation, but few rehabilitation agencies are aware of this valuable resource.

With greater publicity about work incentive options, I am sure that the number of SSI recipients making use of section 1619(a) and 1619(b) will grow. These work incentive options have the support of disability organizations and the support of disabled persons who have studied and experienced in their own lives how important maintaining necessary Federal assistance is to the employment activity of disabled SSI recipients.

[Attachments to the prepared statement follow:]

EXHIBIT A

July 1980

SSA Publication No. 05-10330

1980 changes in social security and SSI disability protection

Major changes in the social security law in 1980 will affect many disabled people entitled to social security or supplemental security income (SSI) benefits. If you receive these payments or expect to, you should be aware of the new provisions.

Several important changes help disabled beneficiaries who wish to return to work. Others alter the method of figuring benefits for disabled people who become entitled after June 1980.

This leaflet briefly describes several of the more significant provisions of the new law. For more information on these and other changes, contact any social security office.

Figuring social security disability benefits after June 1980

Under the old law, some disabled workers with families received social security disability payments as high or higher than their average earnings before becoming disabled. And younger disabled workers had a higher percentage of low earnings years excluded than did older workers when figuring the lifetime average earnings on which benefit amounts are based.

The following changes will *not* affect any disabled people or their families who became entitled to benefits *before* July 1980. But some people who first become entitled to disability benefits in *July 1980* or later may receive a smaller benefit than under the old law. The new law:

- **Limits family benefits**—Total monthly payments to a disabled worker with one or more dependents who are eligible for benefits are limited to the *lower* of 85 percent of the worker's average earnings before becoming disabled *or* 150 percent of the worker's disability benefit. The limit will affect benefits only for the dependents, not for the disabled worker.
- **Changes the way disability benefits are figured**—Previously, 5 years of low or no earnings generally could be excluded in figuring a worker's average monthly earnings for benefit purposes. This often gave younger workers an advantage since benefits may have been based on only a few years of recent high earnings.

  Effective for disabled workers first entitled to benefits for *July 1980* or later, there is a graduated scale for dropping years of low or no earnings according to the worker's age when disability starts:

Worker's age	Number of dropout years
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

Effective *July 1981*, a disabled worker under 37 can have an additional dropout year for each year he or she had *no* earnings and had a child under 3 living in the same household. In no case, however, can the total dropout years—regular and childcare—exceed three.

Encouraging beneficiaries to return to work

The old law enabled disabled beneficiaries (except widows and widowers), whose conditions had not improved, to test their ability to work for 9 months while continuing to receive benefits. After this trial work period, a determination was made whether the work performed was *substantial gainful activity.* If it was, benefits were stopped after an additional 3-month adjustment period. This provision is still in effect.

A disabled person's earnings are the major factor in determining whether the work activity is substantial and gainful. In 1980, a person earning over $300 a month generally is considered to be gainfully working. (There are special rules for blind people who work.)

In the past, some disabled beneficiaries who had an opportunity to attempt working did not since they risked losing monthly benefits and Medicare or Medicaid protection. Those who did return to work and could not continue because of their conditions had to reapply for benefits; and people reentitled to social security disability checks faced another 24-month waiting period for Medicare. In addition, some beneficiaries had special impairment-related work expenses that were so high that it cost them too much to work unless earnings also were high.

The following changes—effective *December 1980* unless otherwise stated—are designed to encourage more disabled beneficiaries to try working:

- **Automatic reentitlement to benefits**—If a person who is still disabled becomes unable to work again *within a year* after social security or SSI payments stop because of substantial gainful activity, the monthly benefits can be started again automatically in most cases. A new application is not needed.
- **Continuation of Medicare**—Medicare coverage generally can continue for *3 years* after a person's social security disability benefits stop because of return to substantial gainful activity.
- **Reentitlement to Medicare**—If a worker starts receiving social security disability benefits again *within 5 years* after they end, and was previously entitled to Medicare, that protection will resume immediately. (This provision also applies to disabled widows and widowers and adults disabled before age 22 whose benefits start again *within 7 years.)* If a person formerly did not complete the 24-month waiting period for Medicare, any months for which he or she received disability benefits during the first period of disability can count toward meeting this requirement in the second period of disability which begins within the 5 or 7-year time requirement.
- **Continuation of monthly benefits, Medicaid, and social services for SSI beneficiaries**—Under the old law, an SSI beneficiary whose earnings represented substantial gainful activity could no longer receive cash benefits and often was also ineligible for Medicaid and social services. Under a *3-year experimental* program starting *January 1981*, all these benefits may continue even though earnings exceed the substantial gainful activity level.

As a person's earnings increase, however, the amount of the cash payments will decrease until they are gradually phased out. But eligibility for Medicaid and social services may continue if a disabled or blind person could not work without this assistance and does not earn enough to pay for similar help.

- **Impairment-related work expenses**—Under the old law, most of a disabled beneficiary's earnings counted in deciding whether he or she could perform substantial gainful activity. Certain impairment-related expenses could be deducted from earnings but only if they were for items needed *solely* to enable the person to work.

  Starting December 1980, additional impairment-related work expenses a disabled person pays for can be deducted even if these expenses also apply to needs for daily living (such as a wheelchair). Expenses for such items as medical devices and equipment, attendant care, and drugs and services required because of the impairment are included under this provision. (These deductions also apply when determining the amount of SSI payments.)
- **Disabled widows and widowers who work**—Under the old law, only disabled workers and persons disabled before age 22 could continue receiving benefits while testing their ability to work. Starting December 1980, disabled widows and widowers also can have a trial work period.

Other changes

Following are some additional changes in the 1980 disability legislation:

- **Payment for medical reports**—Persons applying for social security disability benefits have been responsible for charges made by their doctors, clinics, or hospitals for preparing medical reports about their impairments. Effective *December 1980,* the Social Security Administration will pay a reasonable charge for medical reports it needs and requests. (A similar authority already exists for the SSI program.)
- **Periodic review of disability claims**—Under the new law, an increasing number of allowed disability claims will be reexamined to make sure that only those persons eligible for benefits continue to receive them. In future years, most beneficiaries will have their cases reviewed at least once every 3 years. This means that new medical evidence may be needed from time to time, and beneficiaries may be asked to undergo special examinations or tests.
- **Deeming of parent's income for students receiving SSI**—Under the old law, part of a parent's income and assets was deemed to belong to a disabled or blind child who lived at home and received SSI payments. This deeming continued until the child was 18, or until 21 if he or she was in school. Starting *October 1980,* deeming will no longer apply for disabled or blind students 18 to 21. This means that some students who were not eligible before can now receive SSI checks, and some SSI student beneficiaries may get an increased amount. No beneficiary will receive less money due to the change.

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- **SSI payments to aliens**—Until now, a legally admitted alien could become entitled to SSI payments 30 days after arriving in the United States even if a sponsor pledged financial support. Now, aliens who initially apply for SSI on *October 1, 1980*, or later will be deemed to have the income and resources of their immigration sponsors available for their support. This deeming will continue for 3 years unless an alien becomes disabled or blind after entry, is a refugee, or has been granted political asylum.
- **Sheltered workshop employment**—In the past, payments an SSI beneficiary received for therapeutic activities in a sheltered workshop were considered "unearned" income, and all but $20 a month counted against any SSI benefits payable. Starting *October 1980*, these payments are considered "earned" income, and a greater part of this income can be excluded when determining how much SSI benefits can be paid.

For more information

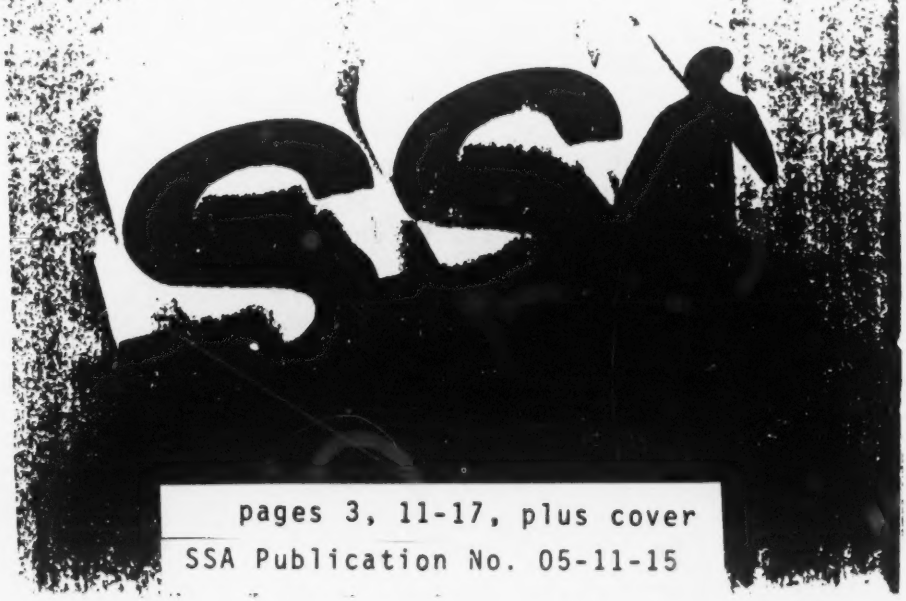
If you want more information about social security or SSI disability benefits, or about the recent changes in the law, contact any social security office. The people there will be glad to help you. You can find the address and phone number by looking in the telephone directory under "Social Security Administration."

U.S. Department of
Health and Human Services
Social Security Administration
SSA Publication No. 05-10330
July 1980

EXHIBIT B

A GUIDE TO SUPPLEMENTAL SECURITY INCOME

JULY 1983 EDITION



pages 3, 11-17, plus cover

SSA Publication No. 05-11-15

A guide to SSI

Supplemental security income (SSI) is a Federal income maintenance program for the aged, blind, and disabled in the 50 States, the District of Columbia, and the Northern Mariana Islands. The program provides monthly payments to aged, blind, and disabled people who have little or no income and resources.

The Federal Government administers the SSI program through the Social Security Administration. It makes the basic payments to recipients, determines eligibility of claimants, and maintains a master record of recipients.

States are required to supplement the Federal payments to people who received a higher amount under certain State assistance programs that existed before 1974. They have the option to supplement the Federal payments to other recipients. Most States also provide Medicaid, food stamps, and various social and rehabilitation services.

Even though the Social Security Administration runs the Federal program, SSI is not the same as Social Security.

The SSI program is financed from general funds of the U.S. Treasury—personal income taxes, corporation taxes, and other taxes. Social Security is funded through the Social Security taxes paid by workers, employers, and self-employed people. The two programs also differ in other areas, such as the conditions of eligibility and the method of figuring payments.

This booklet is designed to assist groups and organizations who have contact with potential or present SSI recipients. It describes the SSI program in detail. A leaflet for potential SSI beneficiaries, *SSI for Aged, Disabled, and Blind People*, is available at any Social Security office.

Income

An individual is eligible for SSI if he or she has income of less than $304.30 a month; a couple is eligible with income of less than $456.40 a month.

If only one member of a couple qualifies for SSI, part of the ineligible member's income is considered to be the eligible spouse's.

If an eligible couple has been separated or living apart for over 6 months, each person is treated as an individual.

If an unmarried child living at home is under 18, some of the parents' income may be considered to be the child's. Allowances are made for the parents' work and living expenses and for other children living in the home. After these allowances are deducted from the parents' income, the remaining amount is used to decide if the child meets the income requirements.

The term "income" includes cash, checks, items received "in kind" such as food and shelter, and many items which would not be considered income for Federal or other tax purposes. Wages, net earnings from self-employment, earned income tax credits, and/or income received from sheltered workshops are considered *earned* income. Social Security benefits, workers' or veterans compensation, annuities, rent, and interest are examples of *unearned* income.

The following income is not counted in determining the amount of a claimant's income:

1 $20 a month of earned or unearned income (except unearned income such as veterans pensions based on need);
2 $65 a month of earned income plus one-half of earned income over $65 a month *or, if there is no unearned income*, $85 a month of earned income plus one-half of the remainder;
3 Refund of taxes paid on real property or on food purchases;
4 Assistance by a State or local political subdivision or Indian tribe which is based on need;
5 Tuition and fees of grants, scholarships, and fellowships;
6 Home-grown produce consumed by the individual and his or her family;
7 Irregular or infrequent earned income if it totals no more than $10 a month;
8 Irregular or infrequent unearned income if it totals no more than $20 a month;
9 Foster care payments for a child who is not receiving SSI payments but who has been placed in the recipient's household by an approved agency;
10 One-third of child support payments received by an eligible child from an absent parent;
11 Earnings (up to $400 a month, but not more than $1,620 a year) of an unmarried child who is a student under 22;
12 Income necessary for fulfillment of an approved plan to achieve self-support established for a blind or disabled person;
13 Work expenses of an eligible person who is blind;
14 Impairment-related work expenses of an eligible person who is disabled;
15 Food stamp assistance;

16 Housing assistance from Federal housing programs run by State and local subdivisions;
17 Benefits, compensation, or items from ACTION programs run by State and local subdivisions;
18 Relocation assistance provided because of property acquisition for Federal or federally assisted projects;
19 Incentive allowances and certain types of reimbursement for individuals in training under CETA programs administered by State and local subdivisions;
20 Grants or loans to undergraduate students from the Department of Education's educational programs;
21 Most Federal judgment distribution payments to members of Indian tribes;
22 Assistance furnished in connection with a Presidentially declared disaster and any interest earned on the assistance for the first 9 months;
23 Interest which is paid on excluded burial funds and left to accumulate;
24 Emergency and other in-kind assistance provided by a private nonprofit organization if the assistance is based on need (this assistance is excluded only until September 30, 1984);
25 Home emergency assistance provided by private nonprofit organizations and certain home energy suppliers if the assistance is based on need and is provided within specified time periods.

Federal payments

The maximum Federal SSI payment is $304.30 a month for an eligible person living alone and $456.40 a month for an eligible couple. These payment levels will increase in the future as the cost of living rises.

If the person or the couple has retirement or other unearned income—such as Social Security benefits, annuities, rents, interest—$20 a month is excluded, and the rest is deducted from the SSI payment, dollar for dollar.

If the person or the couple has earnings from current work, $65 a month is excluded and $1 is deducted from the SSI payment for each additional $2 of earnings. (If earnings are the only type of income the person or couple has, then $85 a month is exempted before the one-for-two rule applies.)

One-third of the SSI payment is deducted if an eligible person or couple is living in another person's household and receiving support and maintenance in kind from that person. This deduction takes the place of counting the dollar value of the support and maintenance as income.

The payment also is reduced if an eligible person or couple is in a hospital or health facility for an entire month and Medicaid is paying over half the cost of the care. If only one member of an eligible couple is in a health facility, the income of each member is considered separately in determining the amount of the SSI payment.

A recipient's first SSI payment is prorated from the date of application or the date of eligibility, whichever is later. For example, if a person applies on the 1st of the month but doesn't meet all the eligibility requirements until the 10th of the month, the first SSI payment will be based on the number of days from the 10th through the end of the month. The payment also is prorated for the month a person becomes eligible again after a period of ineligibility.

If a person is outside the area of the United States and the Northern Mariana Islands for a whole month, no payment can be made for that month.

The following examples give you an idea of how payments are figured for SSI recipients 65 or older. In the case of blind and disabled recipients, there are special income exclusions and certain other provisions - such as the trial work period for the disabled – that do not apply to the aged.

I

Sam Johnson is 66, lives alone in a small house he owns, and his only income is his Social Security benefit of $182.00 a month. He gets $169.80 of this in his check, after his $12.20 Medicare medical insurance premium is deducted.

Income not from current earnings:		
Monthly Social Security benefit	$182.00	
Less $20	− 20.00	
Remainder: Countable income not from current earnings	$162.00	$162.00
Income from current earnings:	None	+ None
Total countable income for the month		$162.00
Basic SSI amount for the month	$304.30	
Less total countable income	− 162.00	
Monthly SSI payment	$142.30	$142.30
His Social Security benefit is		+ 182.00
So his total monthly income will be		$324.30

2

Now let's say Mr. Johnson is married and lives with his wife who is 65. She gets $91.00 a month from Social Security—from which a Medicare medical insurance premium is deducted. The couple's total Social Security income is $273.00 a month.

Income not from current earnings:		
Couple's monthly Social Security benefits	$273.00	
Less $20	−20.00	
Remainder: Countable income not from current earnings	$253.00	$253.00
Income from current earnings:	None	+ None
Total countable income for the month		$253.00
Basic SSI amount for the month	$456.40	
Less total countable income	−253.00	
Monthly SSI payment	$203.40	$203.40
Their Social Security benefits are		+ 273.00
Their total monthly income will be		$476.40

3

Mr. Johnson takes a weekend job which pays $100 a month gross wages. Here's how these earnings affect Mr. and Mrs. Johnson's total income.

Income not from current earnings:		
Couple's monthly Social Security benefits	$273.00	
Less $20	− 20.00	
Remainder: Countable income not from current earnings	$253.00	$253.00
Income from current earnings:		
Wages for the month	$100.00	
Less $65	− 65.00	
Divide remainder by 2	2/35.00	
Countable income from current earnings	$17.50	+ 17.50
Total countable income for the month		$270.50
Basic SSI amount for the month	$456.40	
Less total countable income	− 270.50	
Monthly SSI payment	$185.90	$185.90
Their Social Security benefit is		+ 273.00
And Mr. Johnson's monthly earnings are		+ 100.00
So their total monthly income will be		$558.90

STATEMENT OF WILLIAM MALLERIS, EXECUTIVE DIRECTOR, ROCHESTER CENTER FOR INDEPENDENT LIVING, ROCHESTER, MINN., ON BEHALF OF THE NATIONAL COUNCIL OF INDEPENDENT LIVING PROGRAMS

Mr. MALLERIS. Mr. Chairman and members of the committee, my name is Bill Malleris, and I am executive director of the Rochester Center for Independent Living Programs. The Rochester Center is under contract with the Minnesota Division of Vocational Rehabilitation to assist disabled individuals reach independent and productive lives.

On behalf of the National Council of Independent Living Programs available to assist disabled to mainstream into the community effectively and persons with disabilies, I appreciate the opportunity to discuss with you today the supplemental security income program.

My own experience of having a disability has been a struggle through the years, but I am proud to have met the challenges. I have a rare neurological disability that leaves weakness in my arms and legs, but knowing the educational opportunities available, I was able to overcome and attain a college degree and be actively involved in disability awareness programs.

After college, while living independently in the community, I worked in the private sector, obtaining a true concept of what the challenges are in business, still active with disability awareness. However, the time came that my own experience and background would assist other disabled individuals reach the goals I had attained, therefore, becoming director of the rehabilitation program provided this fortunate opportunity.

It is truly an excellent feeling when one can be employed and assist others through similar experiences and challenges. We must not forget that the general public must be continually educated on the abilities of persons with disabilities in all areas of employment across the Nation.

People are still unaware, though, we have progressed through the years. While walking down the street one day a friend asked does it not bother you the way people constantly look at the way you walk or get up from a chair? My reply was no, for they do not understand; so why hold it against them?

It is my responsibility as a disabled individual to show that I am a person like they are and that there is nothing to fear; therefore, we must collectively diminish the attitudinal barriers and fears between the disabled and nondisabled population of this country.

Disabled persons want to be productive citizens. We want the opportunity to contribute to our society rather than be dependent upon help from the Government. We need a hand up instead of a handout.

In essence, this is why I am here today, to discuss with the members of this committee that the disabled population has the ability to move forward and contribute to our society as all of you are doing as leaders of this nation in the U.S. Congress.

People with disabilities want the chance to live independently, obtain an education, and sustain employment, just as all of you do. However, prior to 1980, there were many disincentives to employ-

ment in social security programs. As a result, many handicapped individuals were forced to depend upon total public assistance rather than pursue their employment objectives and contribute to the funding they need to live in the community.

Finally, we were helped by the passage of the Social Security Disability Amendments of 1980 under Public Law 96-265, section 201 (a) and (b) of these amendments, which is 1619 (a) and (b), as is presently documented, which provide for the continuation of supplemental security income payments, and eligibility for title XIX medicaid and title XX social services assistance for those severely disabled individuals engaged in work activities, have been particularly beneficial.

This amendment provides special payments to employed SSI recipients unless earnings are high enough to gradually phase them out. It also provides special SSI status to some disabled persons, enabling them to receive crucial services such as medicaid, title XIX, and social services, title XX, although they may no longer receive SSI cash payments.

As a result, many people with disabilities have avoided the return to institutionalized care and are continuing their employment activities.

The SSI special benefits amendment, section 1619 (a) and (b), initially was a 3-year demonstration project with strong support for becoming a permanent program, and is now before you to review and authorize for continuation. In order for this committee to realize the impact of 1619, a description of two cases should provide you with the information that will hopefully assist in your decision.

The first is a 26-year-old woman who is a quadriplegic and requires an attendant to assist with her personal care and home care needs such as bathing, dressing, grooming, cooking, shopping and other needs. Vocational rehabilitation helped her complete a college program, providing funds for training and attendant care. After graduating from college, she obtained full-time employment as a computer operator with earnings of $650 a month. Although she briefly received attendant care under a State medical program, she eventually was told she must either quit working or lose her eligibility. Since she was unable to pay this herself, she decided to quit working.

The second case is of a personal friend on SSI who has overcome great barriers with his disability. He is a quadriplegic who has no use of his legs, right arm, and limited mobility of his left arm. He obtained his bachelor's degree in 1975 with assistance from the vocational rehabilitation program. He then moved to Minnesota to continue with graduate school. Since no medicaid title XIX was available to assist with attendant care costs, he was forced into institutional care.

In 1978 he was able to move out into the community of Minnetonka, Minn. due to the attendant care program funded through the Federal and State governments. While finishing his education he began full-time work for a rehabilitation center, but after the 9-month trial work period, he would lose SSI status and therefore eligibility for medicaid title XIX and social services title XX which paid for his attendant care. Ultimately he had to quit an excellent position at the conclusion of his trial work period or be forced to a

life of dependency and institutional care. The cost of such care far exceeds the cost of continuing to live independently in the community with partial benefits.

Passage of the 1980 Social Security Disability Amendments, which included provisions in section 1619 (a) and (b), changed the picture dramatically for these two individuals. In 1981 my friend was able to obtain employment at another rehabilitation center in Minneapolis. He has retained medicaid title XIX and social services title XX and receives some SSI payments which make it possible to pay the additional expenses of living independently. Today he holds a new position with a private, nonprofit consulting firm that provides technical assistance on disability awareness to corporations and businesses in the private sector.

The firm sponsors seminars that show supervisors and management how to work and communicate with disabled employees, thus creating increased employment opportunities for persons with disabilities.

If the SSI special benefits amendment is not continued, he will again be forced to quit his job in order to avoid institutional care, since he cannot afford the cost of attendant services without public assistance while engaged in employment.

Disabled individuals have indicated they are eager to take advantage of the SSI special benefits and pursue employment if it were a permanent program. And this is where the U.S. Congress can make a difference that will have a profound impact on the lives of thousands of severely disabled Americans.

The cases described here indicate the effectiveness of the combined services of vocational rehabilitation, medicaid title XIX, social services title XX, and SSI special benefits.

Employment of people with disabilities has other benefits for taxpayers as well.

A cost-benefit study recently completed by the Minnesota Division of Vocational Rehabilitation showed that the average annual rate of return on tax dollars invested in rehabilitation was 34.8 percent. DVR clients increased their earnings by $11.44 for every vocational rehabilitation dollar spent. They also increased their tax payments, and dependency on public assistance was reduced. As a result, taxpayer benefits averaged $7,758.25 for every client rehabilitated.

In Minnesota, the division of vocational rehabilitation is serving approximately 1,000 supplemental security beneficiaries. While the earnings, taxes paid and benefits reduced are below the averages quoted, the taxpayer profit ranges from approximately $2,000 to $5,000 per client, a significant amount.

However, if you, the members of this committee, do not continue SSI special benefits for disabled persons, the individuals described here will become unemployed and increase the burden to taxpayers with the total cost of their care. It does make financial sense to have a disabled individual employed, contributing to their own support, and sharing the privilege of paying taxes.

Supplemental security income, SSI special benefits, allows the goals of disabled individuals to be realistic and achievable. This committee is in the position of making a difference in the lives of many persons with disabilities. Yes, you will decide whether they

will have productive lives or be totally dependent on the Government. We the disabled are depending on you to make the right decision. And once it is made, the disabled community and Government must work together for a successful implementation, with results that will assure independence and employment for the handicapped.

The National Council of Independent Living Programs will be available to assist this committee and the Social Security Administration in making people better aware of the SSI special benefits program. I am thankful I have had the chance to assist fellow disabled individuals, and now you have the chance to help these persons become productive contributing citizens by allowing SSI special benefits to become a permanent program.

Mr. Chairman, members of this committee, I extend my sincere thanks for the opportunity to speak with you today and share the needs, dreams and aspirations of the disabled in achieving independence and employment. Thank you very much.

Chairman FORD. Thank you, Mr. Malleris.

Ms. Phillips.

STATEMENT OF RUTH E. PHILLIPS, SILVER SPRING, MD.

Ms. PHILLIPS. I wish to thank the subcommittee today for the opportunity to testify about work incentive options for disabled recipients of supplemental security income. The two provisions in the law which expire in December of this year, section 1619(a) and 1619(b), are important for disabled SSI recipients who want to work.

I think this is illustrated from my own experiences as a disabled person who has taken employment, though so far I have not been permitted to utilize the work incentive options expiring in December. Still, my experiences as a disabled recipient of SSI illustrate how important the work incentive options can be.

I had polio at age four, which left me with residual paralysis in both legs. I walk with crutches and a leg brace, and because of back problems related to polio I now use a motorized device called an Amigo for personal mobility. As I speak to you today, I am sitting in the Amigo and you can see that the device is highly maneuverable indoors and thereby makes an excellent assistive device on the job.

I became an SSI recipient in 1975 at the age of 28 while attending college at Texas A&M University, where I studied architecture. At that time I became eligible for medicaid benefits as well. In 1978 I moved to Michigan to continue my studies at the University of Michigan and pursued a doctoral degree in architecture to specialize in barrier-free design.

During the years 1978–82, I was going to school and working part time at the university. I maintained eligibility for SSI and medicaid by utilizing a work incentive option called a self-support plan that had been part of the SSI program since it began.

This self-support plan allows an individual to make money as long as that money goes to pay, say, tuition or other expenses that would ultimately result in that individual obtaining a job. However, self-support plans are limited to 48 months in duration in the

case of disabled persons who are also students. I only found this out when my case was reevaluated in the summer of 1982, and I was told my self-support plan would expire in October 1982.

No one at the local social security office ever mentioned to me that since 1980 additional work incentive options have been available to disabled recipients of SSI. Instead, I only heard again and again that when my self-support plan ended in October even relatively small amounts of earned incomes would render me ineligible for both SSI and medicaid.

No one was ever specific with me about any sort of deduction formula. I was just given the impression that earning as little as $400 a month would terminate me from everything. That was a real problem at the University of Michigan, where my tuition was $2,500 a semester.

So as the fall of 1982 approached and with the end of my self-support plan, I found myself in a predicament. I had an offer for a half-time, 4-month long teaching position at the University of Michigan paying $700 a month. I also had the opportunity to work three-quarter time for the National Center for a Barrier Free Environment and earn $1,200 a month.

The national center is a nonprofit organization here in Washington which gives out information on barrier-free design. The position for the national center was higher paying, but required that I and my 12-year-old daughter relocate to Washington, D.C. Also, a three-quarter time job would leave little time to finish my doctoral dissertation.

The job at the University of Michigan was just right, half-time, but there was a major drawback. I and my daughter could not live on $700 for 4 months if I was also going to lose my SSI and medicaid benefits. In addition, I would be covered by the University's health policy during the 4 months I worked on campus, but prior or existing medical conditions would not be covered during that time period. They are not covered until a year—6 months or a year on the job.

Medical benefits was the crucial issue. At that time not only did I have expenses normally attributed to my disability, such as doctor visits, X-rays, brace repair, crutch replacement, and other costs, I had additional expenses due to a back injury. These included doctor visits, physical therapy, and prescriptive medicines.

Given the information I had received from social security about how income would affect my benefits, I calculated that the job at the university was not economically feasible. In the absence of a full disclosure about work incentive options, I decided to take the position at the national center located here in Washington.

Finally, things have not gone well for me. Initially, the job at the national center was enough for me to live on. But the National Center for a Barrier Free Environment has experienced funding shortages which require many staff to be laid off and my position has been reduced to half-time.

Also and even more difficult for me to cope with, the health insurance company that covers the national center has refused to add me to the agency's group policy. Thus, soon after relocating to Washington, D.C., I found myself with reduced earned income, no health coverage, and no more SSI cash assistance.

Without continued eligibility for medicaid, I have been forced to forego important and necessary medical attention. For example, although I wear glasses, I have not had a visual examination in the last year. Nor have I had a gynecological exam.

The leather padding in my brace has deteriorated and mechanical problems have developed in the brace joints, but I cannot afford to attend to these needs. Consequently, my walking gait has changed, which causes me back pain and increases my disability.

The Amigo on which I sit was purchased by Michigan State Rehabilitation as a work-related assistive device for my job with the national center. Nevertheless, for the Amigo to be truly useful for my employment, it needs some modifications. But the modifications are too expensive for me to purchase on my present salary. Lowering the hand control would strain my back less, and a padded seat would reduce the jarring of my back, and a seat with arm rests, which was supposed to be part of this Amigo, would reduce the stress on my shoulders, which aggravates my back problem.

If I were still eligible for medicaid and SSI, the modifications to the Amigo which I need could be accomplished. Either a doctor could prescribe the changes and medicaid would pay the costs or I would pay the charges myself and claim the expenses as an impairment-related work expense and thereby deduct the amount spent from my countable income.

But because no one in the Social Security Administration told me about these work incentive options, I have had to neglect the needed changes in my Amigo, along with the other medical care I need.

Since the 1st of April, I have been employed half-time at the national center and my financial resources have now gone below my monthly expenses. Phone bills I now owe have not been paid for 2 months. I must ask my mother for a loan. I cannot repay my college loans, which are now coming due, and am receiving notification from the University of Michigan and also Texas A&M University. In addition, I cannot afford to buy clothing for my daughter, who starts eighth grade in September. She, by the way, has grown 4 inches over the last year.

What is more, my dissertation is still not complete. Without the degree completed, I cannot qualify for the level of employment that would render me self-sufficient and no longer in need of any Federal assistance.

But I have been left stranded with my degree in sight and with a self-sustaining career in sight because the Social Security Administration would not inform me and let me mix some benefits and earnings from part-time employment. I was cut off from SSI and medicaid before I truly reached a financial threshold.

Section 1619(a) and 1619(b) were designed to help people just like me. But in order for SSI recipients like me to use these work incentives, we need to be aware of how they can help us attain our employment goals without jeopardizing our health and well-being. I might say, had I known at the time I would not be covered by the medical insurance at my work I might not have taken the job in Washington and I might still be in Michigan, fully on SSI and medicaid benefits.

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My father has been an Indiana businessman with his own business for 30 years. He also votes the straight Republican ticket, except when my maternal grandfather, who is a Democrat, runs for local office. [Laughter.]

I and my other brothers and sisters all helped the family business in Indiana grow, and now even one of my sisters is taking over part ownership in the firm with several of the other employees. I believe in the work ethic and I want to take care of myself and my daughter with my own resources. If the Federal Government will give me and other SSI recipients who want to better themselves a little help while we are starting out in our careers, we will get to the point when we can dispense with SSI and medicaid and instead support these programs with our taxes.

Mr. STARK. Some of us must leave to vote, and the chairman will return. But perhaps Mrs. Kennelly would now like to inquire.

Mrs. KENNELLY. I would like to thank the witnesses for their excellent testimony. It helps us establish a record.

I am pleased with the work Mr. Stark and our chairman have done, that is to get new legislation to encourage these programs. However, I think, Ruth, your testimony highlighted what we are trying to say today: That if a person of your intelligence and endurance did not know about these programs, how in heaven's name can the people I am concerned about who wander about on a hill in my town, having been let out of the institute, ever know about this?

I thank you for sharing your personal life with us. I know it is difficult, but it emphasizes what we are dealing with.

Ms. PHILLIPS. Yes, I really can sympathize with many of these people. We have an individual at the national center who is a volunteer with a mental impairment, and I am concerned presently for her because she is going through a reevaluation currently and is being reevaluated by social security and by vocational rehabilitation.

Mrs. KENNELLY. Let me ask you a quick question. Do you notice a heightening of her concerns and her problem under the circumstances she is facing with the review?

Ms. PHILLIPS. Yes. I think she is very concerned, and I think her attendance at work at the national center has been affected by this. It messed up her previous routine because she has to go in for these reevaluations and now she does not come in until late and she does not function as well at the national center since she has been going through this process. So she is not doing as well on the job as she was.

Mrs. KENNELLY. When the Deputy Commissioner was here talking about the new humane emphasis from top to bottom, humaneness is a word we can put on paper, but it is only through people who are trained and aware of what is transpiring that a program can become humane. And it is only by talking to people like you that we can articulate it ourselves. So thank you.

Ms. PHILLIPS. I would like to point out, I talked to people in Michigan and here in Maryland when I was terminated here, who told me what would happen to me if I did continue to work beyond October. So in both instances no one told me anything about the special benefits.

One time I even asked, is there not something about work-related expenses, and they said, do you have some of those? And I said, well, I am sure I will have a lot of expenses related to this, such as braces, crutches, and things like that.

Mrs. KENNELLY. One quick question. While you are in the District of Columbia would it have occurred to you when you were in Michigan to call your congressional office?

Ms. PHILLIPS. No, because I had only gone to Michigan for school and I really did not know anyone there. I had been prior to this time moving around the country so many times that I frequently do not know who my Representatives are. I go in from school and I am also tied up in that.

Mrs. KENNELLY. That is something I think we have to look into. Excuse me. I must go vote.

Chairman FORD. Thank you.

The Chair would like to thank each panelist for your testimony.

Mr. MATSUI. May I make just one comment for the record? I was going to ask it of Mr. Simmons, but I decided not to.

Mr. Gorski, since the program was enacted, it is more difficult for the handicapped to obtain jobs than it is for the nonhandicapped. Is that correct?

Mr. GORSKI. I would say generally that is true.

Mr. MATSUI. And over the last 3 years since 1980, it has probably been much more difficult, with unemployment reaching almost 11 percent, for a handicapped individual to find work .

Mr. GORSKI. Precisely.

Mr. MATSUI. So the figure of 300 used in the administration's testimony is in your opinion of no relevance in terms of the number of people who are handicapped?

Mr. GORSKI. I think it has some relevance. It shows that, given the fact that very little publicity has gone out from social security, several hundred and in the case of medicaid several thousand people have been able to use these.

Mr. MATSUI. So with the high unemployment and the lack of notification, the figures could be substantially higher.

Mr. GORSKI. Definitely.

Mr. MATSUI. Thank you very much.

Chairman FORD. Thank you for appearing before the committee today.

The committee would like to call on the next panel: Mr. C. Patrick Babcock, director of the Michigan Department of Mental Health; and Mr. Phil Michel, SSI coordinator for the Michigan Department of Social Services.

STATEMENT OF C. PATRICK BABCOCK, DIRECTOR, MICHIGAN DEPARTMENT OF MENTAL HEALTH, ACCOMPANIED BY PHIL MICHEL, SSI COORDINATOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; AND ANNETTE ABRAMS, FEDERAL LEGISLATIVE LIASION, MICHIGAN DEPARTMENT OF MENTAL HEALTH, ON BEHALF OF THE MICHIGAN INTERAGENCY TASK FORCE ON DISABILITY

Mr. BABCOCK. Thank you, Mr. Chairman.

I am Pat Babcock, director of the Michigan Department of Mental Health. With me are two people: Phil Michel on my far left, who is the SSI coordinator for the department of social services in the State of Michigan, who is also the author of a report submitted to our delegation which has also been circulated to the Congress on the disability controversy: "How and Why the Social Security Administration has Reduced the Number of SSI and SSDI Beneficiaries."

Ms. Annette Abrams is also with us. Ms. Abrams is the Federal legislative liaison within the Michigan Department of Mental Health.

The testimony you have heard sofar today has dealt with 1619 (a) and (b) and the extension of those sections, and I would like to say we support the extension of those provisions. We would really like today, however, in our testimony to present another area we think needs attention by the Congress as you look at the SSI and SSDI program.

We are here to encourage that this subcommittee mandate that SSI disability determinations reflect an assessment of the individual's actual ability to work at substantially gainful wage levels. As the disability determination process is currently carried out, we feel thousands of legitimately disabled individuals are denied benefits on the basis of alleged gainful employability.

Functional barriers to employability are ignored because the questions asked during the current process focus solely on objective medical findings and focus too little on equally objective vocational and rehabilitation barriers to employment.

Based on research conducted by the Michigan Inter-Agency Task Force on Disability a task force commissioned by the Governor which includes the cabinet officers involved in human services and education, we propose that work evaluations for functionally limited disability claimants be implemented in the law. For those with identifiable employment potential, we are also proposing training and preparation for competitive employment or employment in sheltered workshops. We feel this will result in a long-term cost savings for the Social Security Administration, the general fund and the States.

Simply stated, the disability determination process has no way to document or interpret those functional aspects of a medical impairment which inhibit an individual's ability to work competitively on a sustained basis. By "functional aspects," we mean simply the ability to perform under the unavoidable stresses of the workplace, the ability to engage in daily work on a continuous basis, the ability to relate to other coworkers and the general public in a positive or nonaggressive manner.

The source of the problem we feel lies in the way the current five-step sequential process is conducted. Based upon the questions of severity and residual functioning capacity; SSA policies ignore a simple fact of life: That an individual's competency—an individual's ability to perform in our society and in a competitive workplace—is equal to the sum of his or her strengths and weaknesses.

Contrary to that maxim, SSA policy states that disability examiners who encounter individuals with multiple so-called nonsevere impairments cannot conclude that several disabling components in

combination prohibit the ability to maintain oneself and to sustain competitive employment.

Before I became mental health director, I served almost 4 years as the labor director in the State of Michigan, both in good employment times and in severe recession times. And clearly, with Michigan going into its 16th month of double-digit unemployment, the marginally handicapped in our State are more severely disadvantaged than ever before.

We think the Federal support system has failed to discern when and how combined impairments affect work potential. This problem can also be discussed in terms of residual functioning capacity or the degree of employment potential remaining after discounting an impairment. On this question, SSA procedures fail to take into account work ability tests which, if consistently utilized, would clearly indicate whether residual employment potential could ever be realized, and if so under what circumstances.

The chart that Mr. Michel is putting on the overhead projector represents the current process. Steps 2 and 5 represent points where we feel the relationship between multiple impairments and work ability or the relationship between residual capacity and work ability should be more reliably documented. This documentation should include the application of accepted assessment techniques by trained counselors who can become personally familiar with the individual claimant. This vocational documentation should become part of the objective information which is reviewed in deciding whether disability benefits should be awarded. In this way, we feel disability examiners and subsequently ALJ's can render uniform, reliable decisions based upon objective assessments of the whole person, including equally weighted medical and functional documentation.

Step 2 in the current disability determination process focuses on severity by basically asking whether the individual's impairment is of such duration and severity as to impair his or her work ability. For thousands of individuals the question cannot be reliably answered based on the data the disability examiners are authorized to collect. Currently, narrow SSA policies force the DDS staff to inadequately assess: First, how multiple impairments affect the individual's productivity; second, the chronicity of the presented problems; and third, the individual's lack of employment experience, as well as the individual's potential to earn some income based upon rehabilitation or supported work.

I would point out to the subcommittee that in Michigan 60 to 70 percent of the individuals denied benefits at step 2 are eventually awarded benefits by the administrative law judge if and when the case is appealed. DDS staff decisions are reversed 70 percent of the time because ALJ's can consider and utilize medical and vocational data which SSA does not require or authorize State DDS staff to use.

It is perhaps ironic that in the State of Michigan we actually use public funds to support an advocacy program in order to help claimants have their cases considered and their benefits reinstated. In Michigan, we use public dollars to challenge public decisions at another level of government. Current eligibility evaluation is so flawed that advocacy programs are needed under the current law

to assist people who simply cannot master the 11-month appeal process and cannot accept the burden of proving the severity of their impairment.

Step 5 on that chart looks at the impaired person's ability to work at any other job which may exist in the national economy. At step 5 the ability to engage in this other work is determined on the basis of the record, a paper assessment with no contact with the individual. This paper assessment takes age, education, and work history into account, but fails to include information on vocational capability. In our State, most people disqualified at step 5 are the chronically mentally ill, which is of course of concern to my department.

The SSDI program was created to insure that workers and their families have some protection against disabilities which occur during the working years. SSI was created to provide a national minimum level of benefits for the needy disabled.

There have always been rigorous review standards for the SSDI program. These standards have been maintained at a high price to applicants who are forced to establish eligibility through a lengthy and often extensive appeal process. Our review of national data indicates that 25 percent of all new SSDI claimants actually have their claims awarded at the administrative law judge level. So, for 25 percent of the claimants, the initial determination has been found to be inadequate.

SSI applicants seldom have the funds, knowledge, resources, or sophistication necessary to assert their rights through an appeal or hearing. Consequently, many who are found ineligible for SSI simply fall by the wayside. I think it is startling that 9 out of 10 individuals that are denied SSI never work again.

Based upon that data, I do not believe that the rigorous procedures used in title II [SSDI] are either appropriate or necessary for SSI title XVI [SSI]. I doubt if SSI claimants will actually feign an illness and risk the discrimination that is inherent in our society toward handicapped people in order to get a maximum of $304 a month.

The cost-benefit ratio of a system that withholds dollars from the needy disabled simply cannot be measured in dollars alone. The costs of such a system are the sum of the betrayed trust, the despair and disillusionment felt by the disabled—individuals who are on the one hand told by employers and personal physicians that they are too sick to work and on the other hand are told by the Nation and the Federal Government that they are too well to receive help.

SSI is supposed to be a safety net for the most vulnerable segments of our society, and as such it must be capable of providing for basic human needs quickly and efficiently. It must also prevent the development of unnecessary dependence. To achieve these goals, we feel SSI must allow more flexible entry standards, as well as have a more comprehensive evaluation component.

We are proposing that SSA insert objective vocational evaluations and rehabilitation services into the current process for SSI claimants. As the chart Mr. Michels will put up indicates, we recommend claimants be screened at step 2 of the sequential process based on two factors:

First, to determine if there is the existence of multiple nonsevere impairments or the existence of a chronic mental impairment;

And second, whether there is the existence of a nonstable work history during the previous 2 years, "nonstable" being defined as the inability to hold a job for more than 3 months on a continuous basis during that period of time.

We feel that decisions using additional criteria in steps 2 and 5 in the sequential process should insure that claimants whose work ability and rehabilitation potential are not clearly apparent would receive necessary, additional assessments. In the model we propose, all individuals passing through the screening criteria would be presumed eligible and would be granted SSI benefits for up to 6 months during which additional vocational information would be acquired.

These presumptive beneficiaries would be referred to State vocational rehabilitation agencies for work evaluation to determine their potential for gainful employment or for development of skills needed for successful sheltered employment. The results of those evaluations would be transmitted to examiners within the State DDS system, to be used in the final determination of disability.

If, based on comprehensive work evaluations, the claimant is found capable of SGA [substantial gainful activity], DDS would deny the individual as nondisabled. If the person is found to have no potential for SGA and it is determined that further efforts at rehabilitation would not be effective, the individual would be found to be eligible for SSI or SSDI.

In cases where it is determined that an individual with proper assistance and training could become gainfully employed, they would be given the opportunity to work through a number of vocational sequences, starting with work activity and sheltered workshops, on to work adjustment, to on-the-job training, to competitive employment. At the point of competitive employment, the individual would become ineligible for continued benefits.

It is important to point out that individuals will fit into the vocational sequence at different points, depending on their skill level. But all points are important in order to be flexible enough to respond to varied individual competencies.

To move from dependency, because of a disability, into an independent lifestyle, the model presumes several events would take place:

First, that rehabilitation agencies would be funded by SSA to conduct workshop evaluations on some of the claimants referred by DDS. In Michigan, we feel that such evaluations can be conducted for less than $500 per claimant. Compared to the administrative costs associated with reconsiderations, and ALJ hearings, it is estimated that SSA would economize in funding adequate up-front vocational documentation.

Second, the State and local rehabilitation agencies would develop and implement rehabilitation plans for employable claimants. This would insure that vocational rehabilitation programs include training and independent living components.

Third, that DDS examiners are mandated to procure workshop evaluations and rehabilitation services and give equal objective weight to both medical and vocational data. We feel this approach

would be cost effective, Mr. Chairman. Currently, denied SSI claimants are retroactively granted benefits by ALJ's after months in the appeals process. Again, our experience in Michigan shows that ALJ's grant benefits in nearly 70 percent of cases.

Chairman FORD. At the ALJ level, overturned?

Mr. BABCOCK. Yes, when we have represented individuals through our publicly supported advocacy program. In such cases, denials are overturned and benefits granted retroactively. During that process the costs of maintaining the individual are frequently shifted to State governments through general assistance programs, as well as creating considerable turmoil and mental, social, and financial pressure on the individual and his family, and running the risk in some cases of reinstitutionalization of the chronically mentally ill.

It is important to note that ALJ decisions to award benefits are frequently based on considering more adequate vocational and medical information, the kind of information this proposed process would give the DDS examiner at an earlier point in the review. Because the proposed sequence would insure adequate case development by DDS, costs associated with the ALJ process and the reconsideration process would be substantially reduced. The benefits formally granted by ALJ's retroactively would be granted in a timely fashion to the individual when they need it, providing relief to States and avoiding in many cases more costly forms of care when someone relapses and goes into an institutional setting.

Society as a whole would benefit from early intervention in the lives of disabled individuals for job training and sheltered employment when assessments indicate the existence of employment potential, rather than waiting until an individual has exhausted 11 to 15 months in appeal and possibly further deteriorated.

Like Michigan, States such as Washington and Massachusetts have supported advocacy programs to assist SSI claimants in the negotiation of appeals. In our State, we spend over $100,000 on advocacy which could be used to conduct treatment in the mental health system. Again, 70 percent of the cases heard at the ALJ levels are overturned, and benefits awarded. The proposed work evaluation sequence would negate the need for States and counties to pursue benefits for clients via costly and time-consuming ALJ appeals, because the model would return the disability program to the course Congress intended: the speedy award of benefits to those whose disability impairs their ability to work gainfully.

We strongly recommend that the subcommittee statutorily mandate the implementation of several changes in the social security disability determination process. These include, first, a provision that SSA undertake policy changes to ensure that the combined effect of multiple nonsevere impairments on employability can be considered in the disability determination process; and second, a provision that SSA develop screening criteria for use in referring claimants for workshop evaluation and rehabilitation services. In providing this mandate to the SSA, we respectfully ask that the subcommittee consider whether additional screening criteria should encompass both the SSI and SSDI claimant groups.

We also recommend that the subcommittee ask SSA for the types of cases and client characteristics most frequently denied at the

DDS level, and approved by the ALJ's. Let me provide one such case that just hit my desk within the past several weeks.

A man who spent 22 years in State institutions is marginally retarded, has an IQ below 70, and is chronically mentally ill. He spent the last 8 years in a group home under a community placement program. He received employment in a sheltered workshop, was found ineligible for SSI, and remained ineligible until we were able to appeal that case to an ALJ, where the denial was overturned. That individual has a legitimate disability. He is simply not employable, even though he tried to help himself by working in a sheltered workshop, which I think should be encouraged.

A third recommendation is that amendments should insure the State DDS units and rehabilitation agencies are adequately funded to carry out the work evaluation and rehabilitation assessments.

Fourth, we recommend amendments authorizing SSA to implement a time limited presumptive eligibility benefit concept. In addition, we would recommend that legislation assert clearly the intent that benefits be continued throughout sheltered work experience, so that individuals and agencies are not discouraged from utilizing current supportive and noncompetitive work options.

Fifth, we recommend that SSA draw upon vocational rehabilitation specialists in developing uniform workshop evaluation standards to be applied nationally by the end of 1984.

Sixth, we recommend that funding authority be modified so that vocational rehabilitation agencies can serve claimants who require independent living skills before they can participate at higher levels of training and employment. At a minimum, legislation should mandate that independent living plans be developed by human service agencies, including the developmental disability unit, vocational rehabilitation, the State mental health and State social service authorities.

Seventh, we recommend that the proposed work evaluation sequence be nationally implemented by December 1984, with implementation on a pilot basis during the interim months.

Eighth, we also recommend that this model be applied both to new applications and to cases periodically reviewed as a part of continuing disability investigations.

Mr. Chairman, we are suggesting that the current definitions and the current application of the definitions simply do not deal with the reality of people who are functionally disabled, legitimately functionally disabled, many of whom have been deinstitutionalized at substantial savings to State, local, and Federal Governments, for many of whom SSI is really a lifeline to stay in the community.

We are extremely concerned that States like Michigan, California, Massachusetts, and others which have taken leadership in trying to promote the civil rights of handicapped people and their right to live in a regular community are being threatened because of actions under SSI particularly, and also under the SSDI program.

We feel this approach provides for assessments based upon objective information which can more clearly determine whether an individual is disabled on a permanent basis or whether an individual is disabled and has employment potential. Such information can

put individuals into a stream of rehabilitation so that they can make some social and economic contribution.

We would be glad to answer any questions the subcommittee may have. We have appreciated the chance to appear here today.

[The prepared statement follows:]

STATEMENT OF C. PATRICK BABCOCK, DIRECTOR, MICHIGAN DEPARTMENT OF MENTAL HEALTH

INTRODUCTION

My name is C. Patrick Babcock, and I am currently director of the Michigan Department of Mental Health. I am accompanied today by Phil Michel, the SSI Coordinator for the Michigan Department of Social Services (MDSS) who recently authored a report to Congress entitled "The Disability Controversy: How and Why the Social Security Administration has reduced the number of SSI/SSDI beneficiaries.

In Michigan the Department of Mental Health has responsibility for serving the mentally ill and developmentally disabled citizens of the state. As chief administrator of a department serving those with mental impairments and functional limitations, and as a former Labor Department Director, I am here to encourage members of this subcommittee to mandate that SSI disability determinations reflect an assessment of the individual's actual ability to work at a substantially gainful wage level. My testimony will point out that, as the disability determination process is currently carried out, thousands of legitimately disabled individuals are denied benefits on the basis of alleged gainful employability. In other words, functional barriers to employability are ignored because the questions asked by disability examiners focus almost solely on "objective" medical findings, and focus too little on objective vocational and rehabilitation reports.

Based on research conducted by the Michigan Interagency Task Force on Disability (MITF/D), my testimony proposes the utilization of work evaluations for functionally limited disability claimants. For those with identified employment potential, I am proposing training and preparation for competitive employment or employment in sheltered workshops. Finally, my testimony will discuss the long term cost savings which will accrue to the Social Security Administration, the general fund and the states through the use of work evaluations, and vocational rehabilitation in selected cases.

DISCUSSION OF THE PROBLEM

Severity and residual capacity: Inadequate assessments

The problem I am here to discuss today, simply stated, is that the disability determination process has no way to document or interpret those functional aspects of a medical impairment which inhibit the individual's ability to work competitively on a sustained basis. By functional aspects, I mean ability to perform under the unavoidable stresses of the workplace, the ability to engage in work on a daily basis, the ability to relate to others in a positive, or at least non-aggressive way. The source of this problem lies in the five-step sequential decision process; it is specifically rooted in the way questions about severity and residual functional capacity (RFC) are asked and answered.

As pertains to severity, Social Security Administration (SSA) policies force well-trained examiners to ignore a simple fact: that an individual's competencies are equal to the sum of his or her strengths and weaknesses. Contrary to this maxim, SSA policy states that disability examiners who encounter individuals with multiple, so-called "non-severe" impairments cannot conclude that several disabling conditions, in combination, can make sustained, competitive employment impossible.

The problem I am discussing involves more than the system's failure to discern when and how combined impairments affect work potential. The problem can also be discussed in terms of residual functioning capacity, or that degree of employment potential which remains after discounting for a severe impairment. On this question, SSA procedures take too little account of work ability tests which, if consistently utilized, would clearly indicate whether residual employment potential could ever be realized, and if so, under what circumstances.

As I discuss the charts included in my testimony, keep in mind that Steps II and V of the sequential process represent points where the relationship between multiple impairments and work ability or the relationship between residual capacity and work ability should be reliably documented. This documentation should involve the

application of accepted techniques by a trained counselor who can become personally familiar with the claimant. This vocational documentation should become a part of the objective information which is reviewed in deciding whether disability benefits should be awarded. In this way, and only in this way, can ALJ's and disability examiners render uniform, reliable decisions based on objective assessments of a whole person—including equally-weighted medical and functional documentation.

The charts in my testimony indicate where work evaluations can and should be incorporated into the current process. From left to right along level 1 are the questions currently asked in the sequential decision process. The question of gainful employment is answered objectively based on actual monthly earnings. As established by Congress and set by the HHS Secretary, earnings over $300 per month demonstrate ability to engage in substantial gainful employment (SGA). Step II in the current disability determination process focuses on severity by asking: is the individual's impairment of such duration and severity as to impair his or her work? For thousands of individuals, this second question cannot be reliably answered based on the data which disability examiners are empowered to collect. Scant resources and narrow SSA policies force DDS staff to inadequately assess how multiple impairments affect individual productivity, the chronicity of presented impairments, the individual's lack of employment experience and the individual's potential to earn some income based on rehabilitation or supported world.

I encourage you to remember that, in Michigan, 60-70 percent of the individuals denied benefits on the basis of severity at Step II are later awarded benefits by an administrative law judge (ALJ). DDS staff decisions are reversed because ALJ's utilize medical and vocational data which SSA does not require its state staff to use and interpret. In contrast to state disability examiners (who have no opportunity to interact personally with claimants), advocates in the state of Michigan are able to procure benefits by presenting ALJ's with adequate medical/vocational case documentation. The current initial eligibility evaluation is so flawed that advocacy programs are needed to assist vulnerable people who cannot master the 11-month appeal process and cannot accept the burden of proving the severity of their impairment(s).

The voids I have just described as inherent in Step II of the determination process become particularly problematic when, at Step III, the question is asked: does the person meet the Listings? Although the Listings are set in regulations, their accuracy in assessing the severity of mental impairments is controversial. Step IV looks objectively at the impaired individual's ability to do his or her past work. Step V looks at the impaired person's ability to work at any other job which exists in the national economy in significant numbers. In Michigan, those who, at Step V, are determined ineligible for benefits are frequently chronically mentally ill.

At Step V the ability to engage in other than past work is determined based on a paper assessment of RFC. This paper assessment takes age, education and work history into account, but it fails to include information on vocational capability.

Overall, the type of person most likely to be denied or terminated under the current process (either at Step II or Step V) is also the type of person least likely to possess the resources and sophistication needed to successfully document their legitimate impairment. The next portion of my testimony will, therefore, focus on how rigorous eligibility criteria and the failure to test actual work ability affect certain claimants more negatively than others.

PROCEDURES DIFFERENTIALLY AFFECT TITLE XVI CLAIMANTS

The Social Security Disability Insurance (SSDI) program was created to insure workers and their families against disability whose onset occurred during their working years. The Supplemental Security Income (SSI) program was created to provide a national minimum benefit standard for the needy disabled. Notwithstanding different goals and sources of financing, identical procedures are followed when determining if an applicant is disabled and eligible for either program.

The Title II, Social Security Disability Insurance (SSDI) program has historically applied rigorous disability standards. These standards are maintained at a price to those applicants who are forced to establish eligibility through a lengthy and often expensive appeal process. Eligibility for one out of every four new SSDI beneficiaries is established at an ALJ hearing. In comparison to SSDI claimants, applicants for Title XVI, Supplemental Security Income (SSI) seldom have the funds, knowledge, resources or sophistication needed to assert their rights throughout an appeal or in a hearing. Consequently, many who would be found eligible for SSI simply fall by the wayside. Most startlingly, nine out of ten of those denied SSI never work again. Based on the facts I have just stated, I do not believe that the rigorous proce-

dures used in Title II are either appropriate or necessary for SSI. Few, if any, find the maximum $304 SSI monthly benefit provided by the federal governemnt a temptation worthy of feigning illness to obtain.

At this point, it will be instructive to compare the SSDI and the SSI populations and the eligibility criteria that members of each claimant group must satisfy. As the table included in my testimony shows, SSDI and SSI claimants must satisfy different criteria on every variable except that variable which equates disability with an inability to work.

	SSDI	SSI
Disability	Cannot engage in any work in the national economy regardless of whether a job exists or if he would be hired if he applied.	Same.
Work experience	Worked at least half of the quarters in the last 10 years or half of the quarters since turning age 21.	Between 25 percent and 40 percent have not worked at all in the previous 15 years.
Sex	70 percent male; 30 percent female	40 percent male; 60 percent female.
Disabling impairment	Mental disorders 10 percent; physical disorders 90 percent.	Mental disorders 30 percent; physical disorders 70 percent.
Age distribution	72 percent between 50 and 65 years old; 9 percent between 30 and 40 years old.	48 percent between 50 and 65 years old; 15 percent between 30 and 40 years old.
Monthly payment amounts	$440 average individual benefit plus $128 per month for each dependent.	$205 average Federal payment, $230 average total payment. No additional payments for dependents.
Resource limits	No limit on the number, amount or kind of resources held by the recipient.	With the exception of a home, a car with moderate value and a few other specified items, resources totaling more than $1,500 result in ineligibility.
Unearned income	With the exception of workers compensation and a few other disability benefits there is no limit on unearned income. For example, interest payments, stock dividends, etc. have no effect on the amount of disability benefit.	Unearned income reduces SSI payments dollar for dollar after the first $20.
Income of other family members	The income of other family members has no effect on the disabled individual's benefits.	The income and resources of other family members are deemed available to the SSI recipent. Unless the family has very limited resources and income, SSI benefits will not be available.

I will quote from a report to Congress prepared by the MITF/D in April of 1983, "Although more rigid disability determination processes have been applied to both the SSDI and SSI programs, the individual effect of additional denials is more cruelly felt by SSI applicants. Profiles of SSI applicants show they are unlikely to have other resources to fall back upon. As noted in the 1979 Report of Social Security Advisory Council: "Since disability insurance benefits are paid without regard to need and can, in many circumstances, provide fairly adequate income support, it is appropriate to restrict eligibility to those whose medical impairments are quite severe. However, in the SSI program where benefits are generally lower and are paid only to those with little or no other income and only limited assets, such strict standards for eligibility are neither necessary nor desirable. *The SSI program should be viewed as a safety net.* It now protects those whose impairments are severe enough to qualify for disability insurance, but whose social security benefits are insufficient to provide a decent level of income. It should also protect those in need whose impairments are not quite severe enough to qualify them for disability insurance, but are severe enough to prevent them from working when the impairments are combined with other personal and economic factors that cannot be measured with reasonable objectivity." [Emphasis added.]

"In summary, applicants for, and recipients of, SSI differ from their SSDI counterparts in the immediacy of their needs, the amount of potential benefits, their age, their disabling conditions, and their employment history. In view of the multitude

of differences, a single definition of disability for both programs is more of a bureaucratic convenience than a logical decision."

The cost/benefit ratio of a system that inadvertently withholds benefits from the needy disabled cannot be measured in dollars. The costs of such a system are the sum of the betrayed trust, the despair and the desolation felt by the disabled poor—individuals who, on the one hand are told by employers and personal physicians that they are too sick to work and who, on the other hand are told by the nation that they are too well to receive help. I am unable to determine what, if any, benefits accrue from such a contradictory system. Consequently, I will proceed to propose to this subcommittee a simple and cost-effective way to determine when needy, disabled claimants cannot work because of severe impairments.

PROPOSED WORK EVALUATION SEQUENCE

SSI stands as a "safety net" for the most vulnerable segments of our population: the blind, the disabled and aged members of our society. As such, SSI must be capable of providing for basic human needs quickly and efficiently. SSI must also prevent the development of unnecessary dependence.

To achieve these goals, SSI must allow more flexible entry into the system, as well as a more comprehensive evaluation component for those found to be eligible for the disability and blindness programs. To these ends, I will suggest a model which will provide for objective vocational evaluations and rehabilitation services for SSI disabled clients.

SCREENING AND WORK EVALUATIONS

As the proposed flow chart indicates, claimants will be screened at Step II of the sequential process based on two new factors: (1) the existence of multiple, non-severe impairments or the existence of a chronic mental impairment; and (2) the existence of a non-stable work history during the previous two years. Employment would be gauged as stable if the claimant had held a job for three months or more in the prior two years. These general screening criteria are offered for subcommittee consideration and refinement.

Specific subcommittee decisions on additional criteria related to Steps II and V in the sequential process should ensure that claimants whose work ability and rehabilitation potential are not clearly evident receive careful assessment.

Following are examples of the sorts of mentally and physically impaired claimants who, lacking adequate vocational documentation, can only gain benefits by appealing to an ALJ. These cases, initially found ineligible for SSI, have been summarized to demonstrate the hardships and tragedies created by the current process. These are typical of numerous cases in Michigan which are currently in the SSI appeals process. Each client has been, or currently is a recipient of state funds in the form of Foster Care, General Assistance or Medicaid.

1. *Mental illness.*—Mr. G has a 69 IQ. He also suffers from schizophrenia, depression, and paranoia. He was in state hospitals from age 18–40. He has spent the last eight years in Adult Foster Care homes. He was grandfathered into SSI from the state aid to the disabled program.

Mr. G was involved in sheltered employment. He was terminated by SSA because of his sheltered employment. He was unable to handle the pressure in the full-time sheltered position. He has had an additional breakddown. He currently works about two hours a day in a sheltered position which has no pressure, as he works at his own pace. He tries very hard to work to his capacity.

The SSI Specialist brought people from the sheltered workshop and a psychologist to the hearing. The ALJ awarded benefits to the client on a combination of factors, including age, education, and work experience.

2. *Developmental disability.*—Mr. W is 55 years old. He has a sixth grade education and a 69 IQ. He spent 30 years in Lapeer and Alpena State Homes. He lives in adult foster care, and was involved with Life Consultation Center in Ottawa County in an attempt to learn the social skills necessary to live outside of a state hospital.

Mr. W worked one summer on a tree farm. SSA closed his case, even though special arrangements were made related to employment. He was not rehired by the tree farm the next summer because of problems he caused with other employees.

Because Disability Determination Services (DDS) ignored all the data related to the client's lack of socialization skills in their denial, the SSI specialist brought the adult foster care provider, the psychologist and case coordinator from the Life Consultation Center to the hearing. The client was awarded his benefits based on a combination of factors, including age, education, and work experience.

3. *Physical impairment.*—Ms. Z is a 37 year old high school graduate. Since 1974, Ms. Z has had 14 major surgeries. The following is the report from her physician. It tells the story well.

"Ms. Z was hospitalized at Pontiac General Hospital April 20, 1981 for seven days. She was admitted and treated for partial multiple obstruction. This is related to her past history of multiple abdominal operations, especially the surgery following the resultant small bowel fistula. This has caused numerous inter-abdominal adhesions which constrict the small bowel, causing a partial obstruction. This results in a great deal of abdominal pain with intermittent constipation and diarrhea. She is still restricted to no lifting, climbing stairs, standing for any length of time, walking or even sitting for lengths of time. Any of these activities will cause the symptoms or partial small bowel obstruction.

"Recently she was found to have a midline incisional hernia, but surgery has not been recommended because of the possibility of ensuing complications which have been prevalent following previous abdominal surgery. She is unable to exercise, which is incapacitating with regard to weight reduction. This in turn has resulted in a great amount of back pain. Any activity causes both abdominal and back pain, and therefore, she is totally disabled at this time and the outlook for the future is extremely guarded."

The SSI Specialist requested a decision from the ALJ prior to a hearing based on the reports. The ALJ awarded a favorable decision to the client based on reports and without a hearing. Ms. Z had previously been denied benefits at application and reconsideration.

These examples point at the need to support SSI applicants until medical and vocational records are complete. In the model I propose all individuals who passed through the screening criteria would be determined "presumptively disabled" and would be granted SSI benefits for up to six months, during which time additional vocational information would be acquired. These presumptive beneficiaries would be referred to State Vocational Rehabilitation agencies for a work evaluation to determine their potential for either gainful employment or for the development of skills needed for successful shelter employment.

Results of work evaluations would be transmitted to examiners within the State DDS to be used in their final determinations of disability. If, based on comprehensive work evaluations, the claimant is found capable of SGA, the DDS would deny the individual as non-disabled. If the person is found to have no potential for SGA, and it is determined that further efforts at rehabilitation would not be effective (due to the impairment), the case would be approved for SSI or SSDI benefits. In such cases, involvement in a sheltered workshop on an ongoing basis might be appropriate, with benefit levels reduced by the amount of sheltered workshop income. Finally, if the person is found to be potentially employable, SSI benefits would be granted during the person's progression (through rehabilitation) to more independent work settings. This latter possibility, involving training and rehabilitation, would vary in length depending on individual competencies. At all points in a work rehabilitation plan, disability benefits would be reduced by the amount of income earned, case management responsibility would be vested in the rehabilitation agency (with DDS diarying claimant progress).

This model presumes that several events will take place:

(1) That rehabilitation agencies are funded by SSA to conduct workship evaluations on some of the claimants referred by DDS. In Michigan, such evaluations could be conducted for less than $500 per claimant. Compared to the administrative costs associated with reconsiderations and ALJ hearings, it is estimated that SSA would economize by funding adequate, upfront documentation.

(2) That State vocational rehabilitation agencies develops and implement rehabilitation plans for employable clients.

(3) That DDS examiners are mandated to procure workshop evaluations and rehabilitation services, and to give equal objective weight to medical and vocational evidence.

COST AND BENEFITS OF PROPOSED WORK EVALUATION SEQUENCE

Currently, denied SSI claimants are granted benefits by ALJ's after months in the appeals process in such cases, denials are overturned and benefits are granted retroactively. It is important to note that ALJ decisions to award benefits are frequently based on exposure to more adequate medical and vocational information than is available to DDS examiners. Because the proposed work evaluation sequence would ensure adequate case development by DDS (in collaboration with vocational Rehabilitation specialists), costs associated with administrative appeals would be

substantially reduced. The benefits (formerly granted by ALJ's retroactively) would be granted in a timely fashion at the front end of the process. Thus, the proposed model would not involve an increased drain on general fund resources. In Michigan, the proposed model would provide a fair and defensible disability determination experience for 350 claimants per month who currently are awarded benefits at the ALJ hearing level.

Finally, society as a whole would benefit from early intervention in the lives of the disabled individuals for job training and sheltered employment when assessments indicate the existence of employment potential. Dependence on federal benefits would not be fostered for other than truly non-employable, non-trainable disabled.

States like Michigan, Washington and Massachusetts have supported advocacy programs to assist denied SSI claimants in negotiating successful appeals. In Michigan, 70 percent of all cases shepherded to the ALJ hearing level by advocates are overturned and benefits awarded. The proposed work evaluation sequence would negate the need for states and counties to pursue federal benefits for clients via costly and time consuming ALJ appeals. Furthermore, the proposed model would return the disability program to the course Congress intended, i.e., speedy award of benefits to those whose disability (in medical and functional terms) impairs their ability to work gainfully.

RECOMMENDATIONS

I strongly encourage members of this Subcommittee to statutorily mandate the implementation of several changes in the Social Security disability determination process:

1. Provide that SSA undertake policy changes such that the combined effect of multiple non-severe impairments on employability can be considered in disability determination decisions.

2. Provide that SSA develop screening criteria for use in referring claimants for workshop evaluations and rehabilitation services. In providing this mandate to SSA, the Subcommittee should consider whether additional screening criteria should encompass both the SSI and DI claimant groups. In making this determination the Subcommittee should seek information on the types of cases and client characteristics which are most frequently denied by DDS and subsequently approved by ALJ's. Screening criteria should be developed which ensure that these "error prone" cases are sure to undergo mandatory work evaluations.

3. Ensure that state DDS's and vocational rehabilitation agencies are adequately funded to carry out the work evaluation and rehabilitation proposals contained in this testimony.

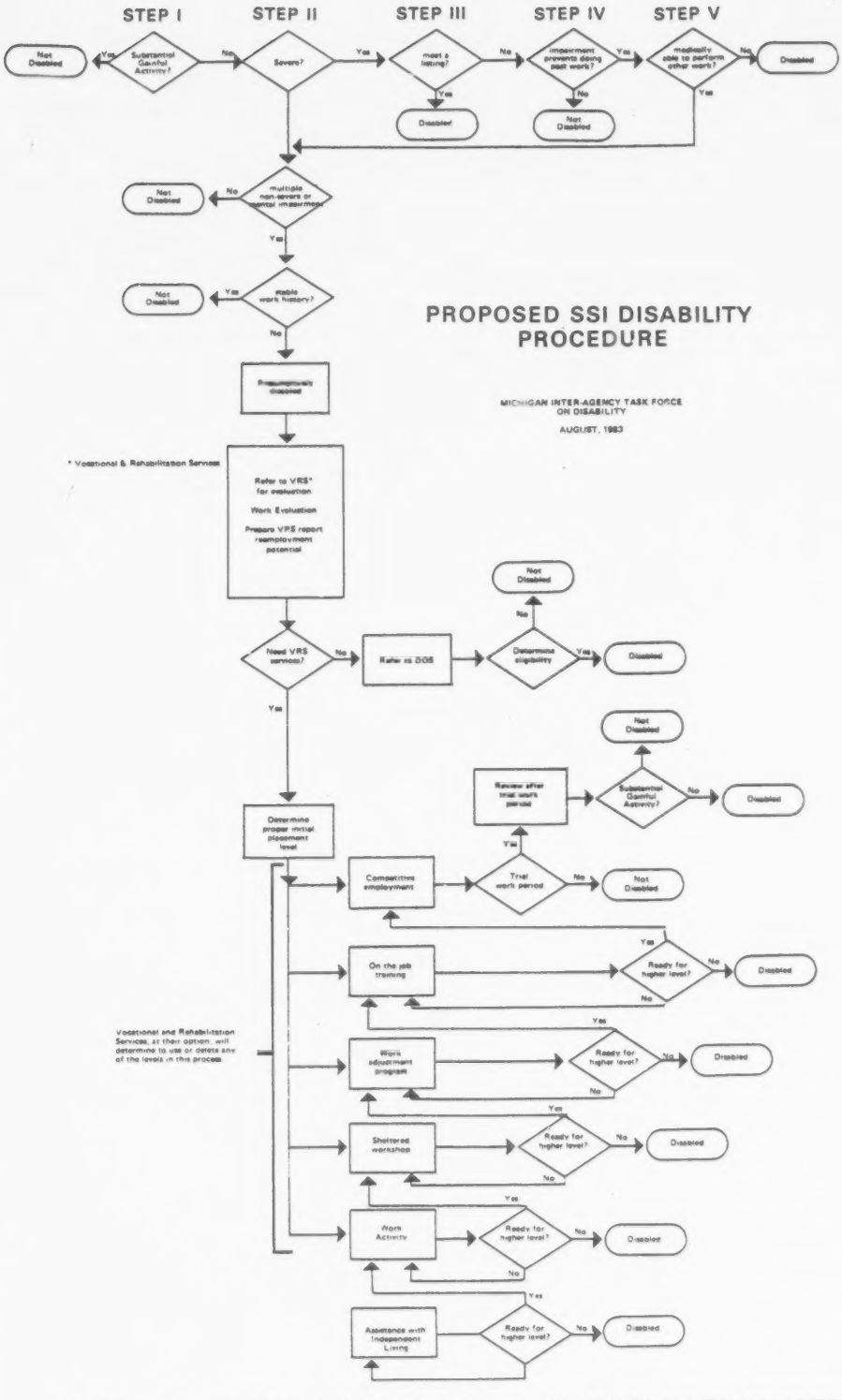
4. Provide that SSA operationalize the time-limited "presumptive disability" benefit proposal included in this testimony. In addition, the Subcommittee should assert its intent that benefits be continued throughout sheltered work experiences so that individuals and agencies are not discouraged from utilizing supported work options.

5. Provide that SSA draw upon vocational rehabilitation specialists in developing uniform workshop evaluation standards which will be applied nationally by December 1984.

6. Provide that funding authority is modified so that vocational rehabilitation agencies can serve claimants needing independent living skills before they can participate in higher levels of training and employment. At minimum, the Subcommittee should mandate that cooperative planning occur among human services agencies to provide independent living experiences for appropriate claimants.

7. Provide that the proposed work evaluation sequence be nationally implemented by December 1984. Implementation should be preceded by the development of pilot projects in a representative sample of states. The sample should reflect various types of interagency relationships existing between state DDS's and vocational rehabilitation agencies.

8. Provide that the model proposed in this testimony will be applied to new applications and to periodic review cases.


STEP I
STEP II
STEP III
STEP IV
STEP V
Not Disabled
Yes
Substantial Gainful Activity?
No
Severe?
Yes
meet a listing?
No
impairment prevents doing past work?
Yes
medically able to perform other work?
No
Disabled
Yes
Disabled
No
Not Disabled
Not Disabled
No
multiple non-severe or mental impairments
Yes
Not Disabled
Yes
stable work history?
No
PROPOSED SSI DISABILITY PROCEDURE
MICHIGAN INTER-AGENCY TASK FORCE ON DISABILITY
AUGUST, 1983
* Vocational & Rehabilitation Services
Refer to VRS* for evaluation
Work Evaluation
Prepare VRS report reemployment potential
Not Disabled
No
Need VRS services?
No
Refer to SSA
Determine eligibility
Yes
Disabled
Yes
Not Disabled
Review after trial work period
Substantial Gainful Activity?
No
Disabled
Yes
Determine proper initial placement level
Competitive employment
Trial work period
No
Not Disabled
Yes
On the job training
Ready for higher level?
No
Disabled
No
Yes
Work adjustment program
Ready for higher level?
No
Disabled
No
Yes
Sheltered workshop
Ready for higher level?
No
Disabled
No
Yes
Work Activity
Ready for higher level?
No
Disabled
No
Yes
Assistance with Independent Living
Ready for higher level?
No
Disabled
Vocational and Rehabilitation Services, at their option, will determine to use or delete any of the levels in this process.

PRELIMINARY SURVEY—WHAT HAPPENS TO MICHIGAN CITIZENS TERMINATED FROM SSI?

(Prepared by Sue Johnson, Lou LaFollette, and Phil Michel, Michigan Interagency Task Force)

I. METHODOLOGY

In the Fall of 1982, the Michigan Interagency Task Force on Disability (MITF/D) undertook an effort to follow 158 beneficiaries of supplemental security income (SSI) whose benefits were terminated between January 1981 and February 1982.

The 158 terminated individuals were first tracked through the Department of Social Services' Client Information System (CIS) to determine what form of assistance, if any, had been sought to replace their SSI income. Individuals not located in the CIS were tracked through the state/county systems of mental health and corrections. Finally, state vital statistics records were checked to discern the rate of deaths among terminated individuals.

II. SUMMARY OF FINDINGS

The data point out two important facts. First, that many terminated SSI beneficiaries, lacking a means of basic support, became eligible for state-funded assistance programs and treatment services. This shift from federal to state responsibility for unemployable and mentally disabled citizens is contrary to Congress' conception of the SSI program. In some cases, the financial burden for previous SSI recipients was shifted from one federal program budget to another. In these latter instances, the Social Security Administration (SSA) saved dollars, but federal tax dollars continued to flow to the disabled through other federal programs to support the disabled through other federal programs.

Second, the survey demonstrated that, although SSI terminations did reduce SSA expenditures, these savings were counterbalanced by increased federal administrative costs.

The results reveal that these terminations saved $366,831 in (federal) Social Security tax dollars and cost at least $341,068 in state dollars.

Specific findings are discussed below.

III. TERMINATIONS REDUCE EXPENDITURES AND INCREASE FEDERAL ADMINISTRATIVE COSTS

A. Permanent terminations

Of the 158 terminated individuals studied, 137 were not reinstated to the SSI benefit roles during the 13-month period studied. At an average benefit level of $230/month, these 137 terminations saved $380,880 in federal Social Security Disability funding.

B. Appeals and reinstatements

Conversely, 21 of the 158 individuals studied appealed their termination decisions and were reinstated to the SSI benefit roles during the period in question. It is important to note that the need to process 21 appeals increased federal administrative costs. Table 1 below demonstrates that SSA expended up to $14,049 to process cases through reconsideration and the administrative law judge hearing.

TABLE I.—FEDERAL COSTS OF APPEALS PROCESS (1977 DATA)

	Per case processing cost	Total processing cost
Reconsideration	$205	$4,305
ALJ hearings	464	9,744
Totals	669	14,049

IV. COST SHIFTS TO OTHER INCOME MAINTENANCE PROGRAMS

Table 11 below shows the various outcomes of SSI termination for the 137 individuals who failed to appeal their termination decision and, hence, failed to be reinstated. Column A shows that 36 of the individuals in this group receive state-funded General Assistance (GA) payments after loss of SSI benefits. At an average benefit level of $180/month, the shift from SSI to GA cost the State of Michigan $78,000/year. Column B shows that 26 of the individuals in this group received Aid to Families with Dependent Children (AFDC) benefits. At an average benefit level of $380/month, the shift from SSI to AFDC cost the state and federal government $119,000/year. This shift from SSI cost the State of Michigan (due to a 50 percent match) approximately $59,500/year.

Column C shows that 3 members of the group studied were admitted to state psychiatric hospitals during the year following the loss of SSI benefits. At an average per diem cost of $94.08, these hospital admissions cost the State of Michigan $103,020/year.

Column D shows that 19 members of the group studied became outpatient clients of county community mental health (CMH) boards. At an average cost of $14.50/day, these services the State of Michigan $100,548/year.

Column E shows that the total cost to the State of Michigan equalled $341,068 due to the termination of 82 individuals from SSI.

TABLE II.—MEANS OF SUPPORT FOR TERMINATED SSI RECIPIENTS

	General assistance (GA)	AFDC	Mental health inpatient	Mental health outpatient	Totals
	A	B	C	D	E
Number	36	26	3	19	84
Percent	22	16	1	12	49
Annual State costs	$78,000	$59,500	$103,020	$100,548	$341,068

V. OTHER OUTCOMES OF SSI TERMINATION

A. Three of the remaining individuals spent time in state prisons subsequent to termination.

B. Three of the individuals studied spent between 9 and 14 months in county jails subsequent to termination.

C. One individual became gainfully employed. This employment led to his termination from SSI.

D. Five individuals died subsequent to loss of SSI benefits.

E. 27 members of the group studied could not be located within the data systems utilized.

Chairman FORD. We will go to the next witness. But prior to that, when you talk about the assistance given to the advocates for the disability claims, are you speaking of cash disbursements to help the applicant through, or are you speaking of an office that carries it all the way to the level of the ALJ's?

Mr. BABCOCK. We are speaking of an office, Mr. Chairman. We have funded the Department of Social Services to hire staff to advocate on behalf of clients, to represent them at the various appeal levels.

Chairman FORD. Is that the $100,000 you talked about, the level of $100,000?

Mr. BABCOCK. That is correct.

Chairman FORD. Are most of those cases submitted all the way to the administrative law judge level?

Mr. BABCOCK. Yes, that is my understanding.

Chairman FORD. They are? What about your State agencies? Do you have any success story with them?

Mr. MICHEL. We do not pick the cases up until they have gone through——

Chairman FORD. Unless they have been denied?

Mr. MICHEL. Yes, at the reconsideration level and the application level. We are, though, supplying to the State DSS the medical records that our department has been able to obtain, to help them in their determinations. Nonetheless, their determinations are still quite frequently to deny until we get to the administrative law judge level.

Chairman FORD. What about the Congress in legislation that has given the State agencies a bit more authority to look at these cases and make more denials or approvals?

Mr. BABCOCK. We would certainly support that with the caveat, Mr. Chairman, that we then run the risk of having 50 disability programs across the country. I think that the fundamental question needs to be addressed on a national policy level. Obviously, some States have different circumstances, and some flexibility is warranted, but the kinds of issues we are talking about really are a matter of equal protection across the country.

Let me point out that our cost, $100,000, is obviously the tip of the iceberg. When someone is federally disqualified, they are eligible for general assistance at about $180 a month in State dollars. We have had cases where people have been disqualified, have had relapses and entered State institutions for the mentally ill at $60,000 to $70,000 per year. We have tracked a small group of terminated beneficiaries and have shared this data with your staff. We found, in the group we could track down, about an equal State expenditure for every Federal dollar saved through an SSI termination, and yet we could only track a portion of the total group.

Chairman FORD. In other words, the successful claims all the way to the administrative law judge level, I guess, would balance out to the $100,000 you talk about that you spend?

Mr. BABCOCK. I think successful claims will exceed that figure because we would avoid institutional costs and general assistance costs, and clearly it is subject to the 70 percent reversal rate.

Mr. MICHEL. Our major expenditure, however, is supporting these people while they are waiting for a claim. We find it takes 10 or 11 months on average to come to a determination by administrative law judges. During that timeframe, we are supporting them on general assistance, and that is the State's major cost.

Chairman FORD. During the 10- or 11-month period, they receive some kind of public assistance from the State of Michigan? Is that correct?

Mr. MICHEL. That is correct.

Ms. ABRAMS. Other States do not have such a program.

Chairman FORD. Would you State your name for the record, please?

Ms. ABRAMS. Annette Abrams. Many States do not have State-based public assistance programs. In Michigan, when people fall out of the SSI program, they fall onto the State rolls. But many States have only county and local assistance programs which in general, provide lower benefits. Other States have no support alternatives when Federal benefits are denied.

Mr. MICHEL. One of the things happening in the State of Michigan is, we have these advocacy programs, and we advocate for this class of clients. Many other States do not, so we end up with two classes of people here: one in a State like Michigan where we have taken an assertive role on our own part to get benefits for these people, and another class in States which do not do that. People in the same condition in those other States do not receive SSI benefits. It is discrimination across State boundaries, essentially.

Mr. BABCOCK. And to go back to my response to your question, Mr. Chairman, I think that is why the fundamental issues require national policy changes. States will vary, as they vary now, in the provision of public assistance or mental health services drastically.

Chairman FORD. Mr. Michel, I think we will recognize you for your statement at this time.

Mr. MICHEL. I have no formal statement to make.

Chairman FORD. All right. I thank you very much.

The committee would like to call Ms. Elizabeth Boggs, a member of the National Governmental Affairs Committee, Association for Retarded Citizens of the United States, appearing on behalf of the Consortium for Citizens With Developmental Disabilities, Sheryl Smith, director of training and technical services, Fairfax County and Falls Church, Va., Community Services Board, along with Merle Arnold, president of Hope Enterprises, Inc., and Mr. Joseph Manes, the senior policy analyst, Mental Health Law Project.

Dr. Boggs, the committee will recognize you first. If you would be so kind to pull up to the table, I would appreciate it.

The Chair will recognize Dr. Boggs at this time.

STATEMENT OF ELIZABETH M. BOGGS, PH.D., MEMBER, NATIONAL GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES, APPEARING ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Ms. BOGGS. Thank you very much, Mr. Chairman.

I am delighted that this hearing seems to be bringing forward a combination of people who have very real hands-on experience at the local and State level on the one hand, and on the other hand those of us who try to view this issue from a broad national perspective, dealing to some extent in greater abstractions, but ones which we hope represent national significance.

The combined constituencies of the organizations I represent this morning are a very heterogeneous group of people. The disabled we are talking about here may be elderly, they may be infants, they may have been disabled all of their lives, or they may have been disabled last year. They may be very bright, able, and articulate, such as those who appeared here earlier this morning, or they may have such mental impairments that they are not able to represent their own interests, and have to have representatives.

Age at onset is an important factor in disability and work ability, because people who are disabled early in life do not get invested in the system in the same way. Moreover, people who have been disabled during their school years have an entirely different educational experience and opportunity than people who have been em-

ployed in the labor force and have the experience of having worked and then lose that ability.

I mention that because I think the concept of work disability is quite simple to comprehend, but obviously difficult to administer. The temptation to oversimplify it or to use dodges or to develop artificial indicators such as medical listings and substitute those for the bottom line, which is, can you do the work, is a temptation which is easily yielded to, but which is clearly unfair and inequitable and does not carry out the purpose of the legislation.

There have been some changes in the definition of disability over the years, but basically the concept has been there. The main change has been that we no longer use the words "permanent" and "total." We do recognize—and I was delighted Mr. Campbell recognized this morning—that some effort to work is not incompatible with the concept of work disability developed by the many authors over time of the Social Security Act, even though substantial gainful activity represents a kind of arbitrary boundary, and wherever you put that dollar sign is somewhat arbitrary.

Nevertheless, the notion that disabled people can and should aspire to work and should be able to demonstrate and try themselves out before they are declared totally ineligible for benefits is a very important one, and one we feel should be maintained.

You have had plenty of documentation this morning, and at other times, of the defects and deficiencies in the process of disability determination, and I want to reemphasize that not only must those defects be remedied, but also the target of work disability as a concept must be constantly kept to the fore, and not replaced by ancillary gimmicks.

I further want to emphasize that many of us who speak for the disabled necessarily see the four titles of the Social Security Act, title II, title XVI, title XVIII, and title XIX, as inevitably intertwined and mutually supportive, and we want to resist any tendency that might arise to disassociate those systems. The fact that in recent years the responsibility has been divided up among the various substantive subcommittees in the Ways and Means committee puts us a little more at risk that a total concept will not be fully supported, and we look to the members of this subcommittee to assert themselves as members of the full committee and to see the system as a whole as well as doing your individual detailed work on the specifics of title XIX.

We want to reinforce most strongly your inclination to extend section 1619. To make it permanent would obviously be preferred, because clearly the knowledge that it is permanent is part of what we need to add to the incentive for people to make use of that mechanism. It is absolutely essential to extend it for a significant forward period, it seems to us, because it has not been adequately tried out. Quite aside from the question of whether there has been enough publicity, there is not enough time in the pipeline in the less than 3 years it has been in effect to determine the impact. In particular it is highly desirable, and indeed necessary to research out the relationship in 1619(b) between medicaid and other available health care coverages.

Somehow, people assume that once you have gone off SSDI or SSI, you will automatically have not only the means but the access

to third party health insurance systems which are adequate to meet your needs. This is absolutely not true with disabled people. You heard this morning of the problem of getting coverage for a preexisting condition even when the employee was employed by an agency that had a reasonably good plan. That is one of the problems. Very frequently people on SSI have access only to marginal portions of the labor market where the fringe benefit package is trivial if not nonexistent. In particular, it does not cover those kinds of expenses which are in the nature of need for chronic conditions.

So, we reinforce what has been said here before about 1619 (a) and (b). We think the committee did good the first time, and we think it is absolutely essential we be reassured at the earliest possible opportunity that extension is going forward, and that the effects are going to be well documented and researched in the future.

We are pleased, we who are interested in mental retardation, as I particularly am, are pleased with the proposal for a long-term research project on transitional employment for the mentally retarded, but it is not yet even designed, 3 years after the fact. So, we have got to go on.

I would like to mention that as of 1979, which is the latest documentation I have, there were about 77,000 disabled people on SSI who had some income from work. Most of them, the majority of them were under 35. Again, the incentives are there for younger people, and of course from a cost beneficial point of view that is important, too, because those people, if they stay on the rolls, represent a cumulative per capita cost that is larger than is occasioned by people who come on the rolls at 55 or 60 and then move on to retirement.

So, we see those attempts at employment as indicative. That 77,000 represented about a 40-percent increase over data available for 1975. Assuming we continued to increase at that rate, we may have 100,000 people receiving SSI with some earned income at present. I mention this figure because when you talk about 5,000 utilizing 1619 (a) and (b), and if you compare it with the number of people employed, and more particularly the number of people whose employment earnings exceeded the average of $81 a month, it does not seem like such a small figure percentagewise. I wanted to emphasize that.

There is one other thing I would like to extemporize on. That is the QMRP. The "qualified mental retardation professional" was a term developed in the course of the title XIX regulations for intermediate care facilities for the mentally retarded, and it describes a person who has qualifications in one of five or six disciplines, and who serves as the coordinator of a team of people whose job it is to evaluate the individual and develop a plan for that person's habilitation.

To say that the QMRP is uniquely qualified to assess work disability would, I think be erroneous. To say that the QMRP has access to knowledge developed on an interdisciplinary basis, developed by members of the team of which that person is serving as coordinator, would be very accurate. Usually, that team has a physician, and almost certainly a psychologist. There is a link there to people who are qualified in this area, and certainly if the person is

of an age and disposition to have employment potential, then it is the responsibility of that team to develop that potential.

So, the QMRP is a valuable resource with access to useful information for the DDS but I would not want this hearing to go on record as suggesting that a QMRP is a substitute for a clinical psychologist or, for that matter, a psychiatrist.

Those are the main points that I wanted to make, in addition to the written statement, which I hope will be entered in the record.

Chairman FORD. Your written statement will be made a part of the record, Dr. Boggs.

Ms. BOGGS. I avoided repeating all of that, particularly the things that have been said before. I think we have had good testimony today.

[The prepared statement of Ms. Boggs follows:]

STATEMENT OF ELIZABETH M. BOGGS, PH. D., PRESENTED ON BEHALF OF AMERICAN COALITION OF CITIZENS WITH DISABILITIES, AMERICAN FOUNDATION FOR THE BLIND, ASSOCIATION FOR RETARDED CITIZENS, EPILEPSY FOUNDATION OF AMERICA, NATIONAL ASSOCIATION OF MENTAL RETARDATION PROGRAM DIRECTORS, NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED, NATIONAL EASTER SEAL SOCIETY, NATIONAL MENTAL HEALTH ASSOCIATION, NATIONAL SOCIETY FOR CHILDREN AND ADULTS WITH AUSTISM, AND UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

The Consortium for Citizens with Developmental Disabilities and related organizations have important interests in Supplemental Security Income and Medicaid as these two programs pertain to disabled adults and children. CCDD commends this committee for its timely attention to emergent issues affecting our constitutents. Our concerns embrace all disabled person of any age or type of disability. At this time we wish to focus particularly on those who are less likely qualify for "disabled worker" benefits, to wit: disabled children and those adults who became disabled early in life. These persons are also least likely to have savings or other economic assets of their own.

About 230,000 blind and disabled children receive SSI; and an estimated four to five hundred thousand adults who receive SSI do so because of disabilities originating in childhood. It is known that about 165,000 of these receive both SSI and adult disabled child's Social Security benefits.

INTERDEPENDENCE OF SYSTEMS

Even without referring to interfund borrowing—in a much more fundamental way—the four programs authorized by Title II, XVI, XVIII and XIX of the Social Security Act are highly interdependent. Together they are designed to maintain the cords and sinews of the social safety net for persons who, because of age or disability, are not expected to be self-supporting through their own work. These four entitlement programs are component quadrants of a larger whole; they address respectively (1) basic maintenance and (2) health care for (3) those insured through payments into the Social Security trust funds and (4) those for whom this protection is inadequate to assure minimum protections as defined through means tests applied to income and assets. We here are primarily concerned with the application of this four part system to persons who are severely disabled.

The name applied by the Congress to the new Title XVI which went into effect in 1974 was Supplemental Security Income. It was chosen to emphasize the intention that use general revenues to fill out support for those who, for one reason or another, do not receive sufficient social security to assure minimally adequate food and shelter and health care. When the reason for this inadequancy is work disability, the definition of disability should be the same in all quadrants.

Admittedly our present definition leaves a gap between the concept of "substantial gainful employment" and minimally adequate self-support. This gap disadvantages those persons who can earn at the level of SGA but cannot earn a minimum wage on a full-time basis. Eventually this gap must be addressed, (and with attention to the higher costs of living for disabled persons with various disabilities) but at this time we must at least maintain the intended complementarity between entitlements to Social Security based on disability and those entitlements to SSI which are

similarly based. This consistency need not prevent us from recognizing the differences created by the application of the means tests in the Title XVI.

The troubles identified in the CDI of disabled worker beneficiaries under Title II must not only be solved, but their implications for new applicants who are disabled and who apply under either Title II or Title XVI must be averted. We do not favor the proposals advocated by some to salvage "old" standards of disability only for SSI while permitting more arbitrary and mechanisable criteria to be applied to SSDI applicants. We see that as a short term solution which may well harm both groups in the long run. We therefore urge this Committee join forces with the Subcommittee on Social Security in seeking common solutions to problems of determining eligibility based on disability. We strongly commend your colleagues, Mr. Shannon and Mr. Stark, for using this approach in H.R. 2987. Even though this bill has been assigned to the "other" committee we urge you to consider and support its provisions as they impact on SSI applicants and recipients as well as SSDI beneficiaries.

DETERMINATION OF DISABILITY—SUBSTANTIVE ISSUES

The essence of the definition of disability is conceptually simple—inability to engage in substantial gainful employment because of any one (or combination) of a vast array of physcial or mental impairments. The impairments themselves are indicators—not definers of disability, necessary but not sufficient. The ultimate test of "severity" is functional—can the person work? When in doubt find out. Outcomes of work evaluation and trial work become component factors to be considered. Gainful employment cannot be substantial unless it can be sustained over a reasonable period of time.

Work evaluation, trial work, transitional work and reentitlement

Most persons with severe disabilities orginating during the developmental period have medical, social and economic needs distinguishable from those persons who become disabled later in life and who may qualify as "disabled workers." One area of special difficulty is that of making an initial entry into the work force.

In recent years a number of research studies have reinforced the notion that under certain circumstances and with extended training many persons with substantial developmental disabilities may become quite productive. However, the need for supportive services and the consequences of losing benefits, especially medical benefits as a result of demonstrating "substantial gainful activity" are especially devastating for many developmentally disabled people because they so frequently find themsevles in the marginal labor market without reliable substantive fringe benefit packages. Therefore it is especially critical that they receive the advantages which the Congress intended to extend through its provisions for "transitional work" and "trial work". Although the concept of trial work has been around since the early days of Title II SSDI, and was coopted into SSI in 1972 amendments, the idea of reentitlement period was incorporated only in 1980 and has not yet been in place long enough to be evaluated properly.

It is important to note that the effect of earnings during a trial work period is different for DI beneficiaries than for disabled recipients of SSI because the amount of an SSI payment may be reduced by earnings from month to month. According to Section 2132 of the 1982 edition of the Social Security Handbook (referring to SSI):

Services rendered during a trial work period are not considered in determining whether a disability has ceased. The work is evaluated after 9 work months. If it is found to be substantial the disability is considered to have ceased and the right to payments as a disabled individual will end. A 15-month reentitlement period may follow the 9-month trial work period. During those 15 months the individual may be paid for months of low income.

Income during a trial work period may be high enough to prevent payments of SSI benefits for some months but does not interrupt the 9-month work period or the reentitlement period.

The trial work period: A. Begins as early as the month in which the person becomes eligible. B. Ends with the ninth month (not necessarily consecutive) in which services are rendered, the fifteenth month of the reentitlement period, or, if earlier, the month in which the disability ends. C. May not begin, if an individual has already had a period of trial work while eligible on the basis of the same disability.

Although provisions for a trial work period have been in the law for some time, recent experiences show that they are often being implemented in a trivial way. The amount of earnings considered to "trigger" a work month (counted as one of the nine allowed) is not, set in the law; by policy it was set at $50 in 1968. Today it is $75, just one quarter of SGA, yet a "trigger" month may be viewed as presump-

tive of recovery. Moreover, sporadic, episodic work, or work performed under circumstances which are not typical of the open market is now being counted in some cases.

Section 305 of H.R. 2987 addresses some of these concerns. We believe that the concept of trial work can be further strengthened by assuring that:

(1) "Transitional work" or other work which is performed as part of a rehabilitation program (not limited to programs conducted under the auspices of state vocational rehabilitation agencies) is not counted as part of "trial work."

(2) A month of "trial work" is one in which the earnings are such that they equal at least that rate (now about $125/mo.) which—if annualized—would entitle the "worker" to four quarters of primary coverage under Title II.

We are sensitive to the concerns that Congress may over-legislate matters that should be worked out in regulations. We would like to see SSA respond to the above suggestions in ways which will obviate the need for legislation.

Special problems of disabled SSI applicants recipients

We strongly support Mr. Stark's bill targeted on special problems in SSI, H.R. 3074. In addition to placing temporary moratorium on the continuing disability investigations of Supplemental Security Income disability beneficiaries having mental impairments, H.R. 3074 contains provisions which:

1. Make permanent those sections of the Social Security Act which provide for the continuation of special cash assistance and Medicaid coverage for disabled SSI recipients who are able to work in spite of their disability;

2. Require the continuation of benefits during the appeals process; and

3. Require SSA to determine through personal contact whether mentally disabled persons require assistance in complying with SSA's instructions under the SSI program.

Because SSI recipients, whether elderly or disabled, have by definition very limited cash reserves, it is especially important that their income not be cut short arbitrarily and that they be sustained through the appeals process. The fact that this process may be unreasonably prolonged makes this protection all the more essential.

INCENTIVES AND DISINCENTIVES FOR DISABLED PERSONS TO ATTEMPT WORK

H.R. 3074 also addresses the urgent need to extend Section 1619 beyond its statutory termination date of December 31, 1983. As you know this section permits a person with low earnings who works despite severe impairments to maintain his status as an SSI recipient (with reduction in payments) even though his gross earnings may exceed SGA. "SGA" alone would keep the person in poverty and does not even approach the Federal minimum wage. Section 1619 was an eminently rational proposal when enacted, and remains so. Three years is an inadequate time to test this proposal, as indicated by the fact that final regulations have only recently been issued and that SSA is only now initiating the studies designed to test the long range impact.

Although the provision was instituted primarily at the instigation of relatively young and very articulate adults with severe physical disabilities, including Viet Nam veterans, it has important implications for persons whose impairments originate in childhood and include limited intelligence or limited ability to communicate. This is particularly the case with persons who are mentally retarded. Such persons constitute about 13 percent of those disabled persons who are newly allowed SSI benefits each year and constitute a still larger proportion of those in current payment status. SSA has recently announced an RFP for an initial contract to design what may be a ten year study on "transitional" work for this group. The support systems needed to enable these persons to be productive may not be as easy to visualize but do include "impairment related work expenses," social services, and access to necessary health care.

As already stated, many of those classed as developmentally disabled will be employed (if at all) only in marginal jobs with poor job security and poor fringe benefit packages. Congress has recently been facing the issue of health care for persons who have lost their group insurance as a result of unemployment. This problem is endemic even in times of prosperity for persons in marginal jobs. Moreover, even when some health insurance is associated with a job open to members of this group, it may well not cover those services most needed by persons with chronic as opposed to acute conditions. The cutbacks in Title XX have further aggravated these deficiences. Moreover, since Medicaid coverage is so dependent on state planning, the adequacy even of Medicaid for the person who depends on SSI (as Federally deter-

mined) is by no means assured. This link needs to be strengthened for at least three classes of disabled persons: those receiving SSI, those who are marginally employed despite disability, and those who become ineligible for SSI because they receive SSDI and thereby have to substitute the even less adequate provisions of Medicare for Medicaid.

We do not expect this Subcommittee to come up with the solutions to these problems this summer; future solutions will have a better chance, however, if we at least do not step backward now by allowing Section 1619 and its correlates to expire.

DETERMINATION OF DISABILITY—PROCEDURAL ISSUES

The many weaknesses recently revealed in the disability determination processes under Title II (both of long duration and as reinterpreted in the past two years) directly threaten those entitled to assistance as needy disabled persons under Title XVI. Although the emphasis and outcry to date has centered on disallowances for those already receiving benefits under the Disability Insurance (DI) program, the effects of criteria applied in CDI may soon be felt even more widely among initial applicants under both Titles II and XVI, as well as by persons who will increasingly come up for review (redetermination) under SSI. Steps must be taken concurrently on all fronts to abate this erosion. As an indicator of current distress please note that "hearing receipts" under SSI are expected to rise from 53,112 in 1982 to 91,700 for 1983. For concurrent DI/SSI, a rise from 82,773 to 91,000 is expected. Pre-effectuation reviews are just getting into high gear. Their effect is yet to be reflected in statistics.

For obvious reasons SSI recipients are even more vulnerable to loss of benefits than are DI beneficiaries, since they are not allowed a nest egg. In addition SSI potential recipients are often quite impaired in their ability to cope with bureaucrats and to respond to formal communications and must often depend on others to assist them in pursuing their claims in a timely way. Current SSA practice, based on court order, provides for a continuation of SSI benefits during the appeals process. We strongly support incorporating this practice into law. We believe that individuals who decide to exercise their appeal rights are entitled to a continuation of benefits as a matter of equity. The continuation of benefits recognizes that a final decision has not been rendered and increases the individual's ability to exercise his appeal rights fully.

We appreciate that in the past few months a number of steps have been taken in SSA to respond to the criticisms by disenfranchised DI beneficiaries and their advocates in the Congress and that these changes in procedural criteria will affect disabled SSI applicants. We are also pleased to note that SSA is projecting a 1983 DI allowance figure of 311,000 for disabled workers, up from 212,000 in 1982. However, this 1983 figure is still down about 13 percent from the 1981 total although the application rates projected in 1981 and 1983 are comparable. One in four applicants is being allowed this year as compared to only one in five in 1982. (1983 Annual Report—SSA p. 44).

It might be argued that the war on disabled workers has bottomed out. Before coming to a quick conclusion it is well to note, however, that the projected absolute number of allowances in 1983 is less than in any other year since 1967, and that the projected 1983 incidence (ration of allowances to number of workers insured for disability) is by far the lowest in history (except for 1982). At the same time the average benefit is also being reduced.

A parallel effect is beginning to be all too apparent in the SSI caseload. The projected number of new awards for 1982 is down one third from 1981. Moreover, the total number of persons receiving SSI payments as disabled is now declining, although there are several demographic reasons why it should not.

SSI AS SAFETY NET UNDER OASDI

People who receive Social Security on the basis of disability are more likely than others to need SSI. They become "dual beneficiaries." Concurrent receipt results when the Social Security benefit is lower than SSI. As will be seen from the accompanying chart the effect is most pronounced for women (including widows) and children over 18. Most persons who are disabled before age 22 receive Social Security benefits, if at all, only as the dependents or survivors of insured workers and are referred to as "adult disabled children." Adults with these characteristics constitute more than 20 percent of disabled SSI recipients and account for a majority of adults under 35 in that program. Put differently, about 36 percent of the adult disabled child beneficiaries also receive SSI benefits. This is a measure of their low Title II benefit levels. These are doubly limited—directly by statute (50 percent of parental

PIA for auxiliaries, 75 percent for survivors) and indirectly by the workings of the maximum family benefit. If the disabled person is one of three persons drawing on the record his benefit may be cut to 25 percent—37 percent of the PIA. Thus, of the 900,000 to 1 million developmentally disabled persons dependent on Title II and/or Title XVI only about one-third do not depend at least partly on SSI.

NEED FOR ASSISTANCE TO APPLICANTS WITH IMPAIRED COPING SKILLS

A majority of persons with developmental disabilities have mental retardation as a primary or secondary impairment. Such persons are often unable to comprehend the requirements of law. It is therefore important that legislation focus on the need to make sure that potential or actual recipients are properly advised and assisted in obtaining benefits to which they are entitled. It may be desirable to emphasize that whenever reference is made to notice, or assistance, or opportunity for a personal appearance it is understood that guardians or representative payees, or next of kin are to be notified or advised, or permitted to appear, as appropriate, and that this outreach should be extended to initial applicants as well as those subject to CDI. It appears to us to be the intent and practice of the Social Security Administration to work through such representatives if they are formally appointed but a caveat may be in order so as to assure that the intent of these provisions is to be achieved. We need a fail safe mechanism to protect persons who are impaired in their ability to advocate vigorously for themselves because of the very disabilities which should entitle them to benefits.

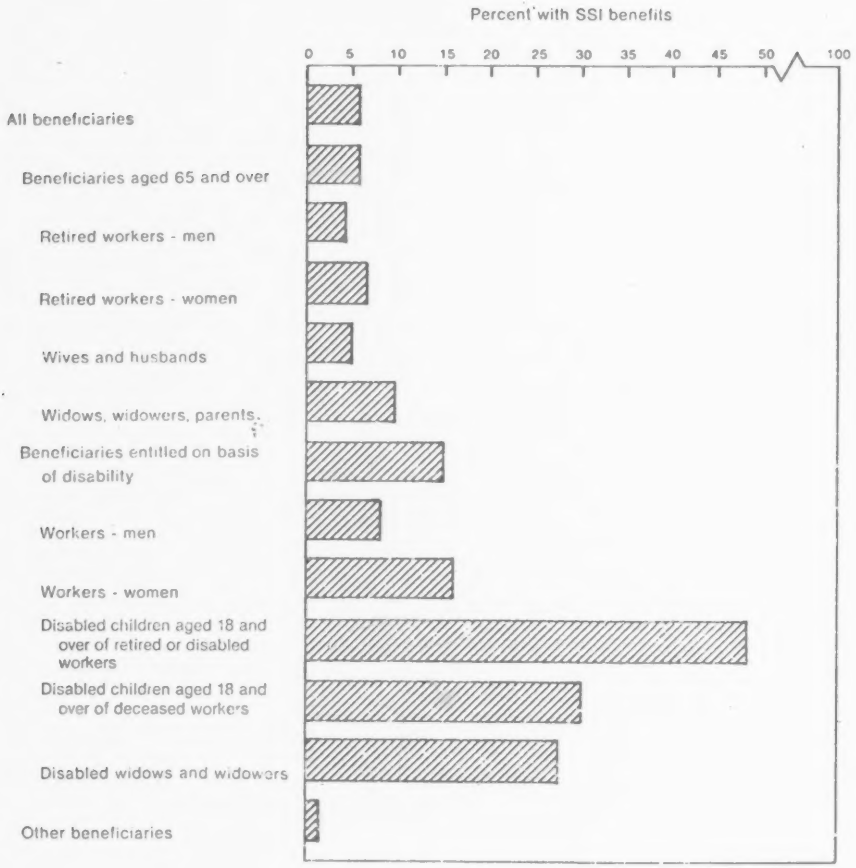
REINSTATEMENT RETROACTIVITY

We call your attention particularly to Section 201, items (4), (5), and (6) of H.R. 2987 as these are of particular concern to persons with developmental disabilities. In order to be eligible for adult disabled child's benefits the applicant must have been continuously disabled since childhood. For this reason an erroneous determination of "not disabled" if entered in the records (perhaps in connection with an application for SSI) and not expunged could well jeopardize the individuals' entitlements to survivor's benefits at a later date.

SUMMARY

We support those provisions of the Shannon and Stark bills which are directed to procedural defects affecting disabled people now or potentially eligible for SSI beneficiaries; we strongly advocate the continuation of the 1980 amendments providing work options for persons with severe disabilities. We oppose a dual definition of disability which would differentiate DI beneficiaries from SSI-D recipients.

CONCURRENT RECEIPT OF OASDI AND SSI BENEFITS, DECEMBER 1981



Chairman FORD. Thank you very much, and thank you for your testimony.

At this time, the Chair will recognize Ms. Sheryl Smith, and I would ask Mr. Pease to come and take the chair at this time. The Chair must run off, and I will be back in a few seconds.

STATEMENT OF SHERYL SMITH, DIRECTOR OF TRAINING AND TECHNICAL SERVICES, FAIRFAX COUNTY AND FALLS CHURCH, VA., COMMUNITY SERVICES BOARD

Ms. SMITH. I, too, have testimony I have distributed which I will not bother to read, but I would like it entered into the record.

Mr. PEASE [presiding]. Without objection, so ordered.

Ms. SMITH. I am Sheryl Smith, a resident of Fairfax County, Va. I am director of training and technical services for the Fairfax, Falls Church Community Services Board. I have written a brief of experiences involving problems of the mentally retarded sheltered employees in Fairfax County with regards to employment regulations as applied to supplemental security income and medicaid. That is the brief I just distributed.

In April of this year, I learned that State and local medicaid administrators and staff apparently did not know of the section 1619 work incentive option of the Supplemental Security Income Act. Forty-four mentally retarded individuals in northern Virginia who were SSIA recipients, achieving substantial gainful activity in a sheltered work setting, being paid on a commensurate wage basis, were terminated from SSI, and more importantly, from medicaid, because no one knew about the section 1619 option.

Under section 1619, these employees should have been entitled to medicaid coverage. It also appears that they were denied for lack of knowledge of that existing option. In fact, the 1619 option could not be found in the local Virginia medicaid manual in Fairfax County, Va.

I had worked with a similar problem concerning lack of communication in the implementation of SSI and the resulting rules and regulations in 1974. At that time, I was employed in Georgia. The problems were resolved through training programs for service providers, parents, guardians, and medicaid administrators.

I believe that a thorough training of parents, guardians, service providers, and medicaid administrators is required now. The service and care you provide in the work incentive option program is desperately needed, and should be continued. Please consider recommending Government training programs or Government individuals who are so designated who can encourage publicity for the provisions that are legislated and used in this program.

I am now open to any questions you may ask.

Mr. PEASE. All right. Thank you. I think we will take testimony from all the people on the panel before we go to questions.

[The prepared statement follows:]

STATEMENT OF SHERYL M. SMITH

Good morning, ladies and gentlemen. I have been asked to discuss with you northern Virginia's various levels of vocational employment for mentally retarded individuals and the relationship to the SSI disability program.

In northern Virginia there is a range of sheltered vocational services for mentally retarded employees whose productivity ranges from 5 percent to over 50 percent of the normal productivity as compared to a non-handicapped worker.

In addition to the normal work activities centers and sheltered workshops, there are several added dimensions to vocational programs for the metally retarded residents of Fairfax County, Fairfax City and Falls Church City, Virginia. Four work activity centers and/or sheltered workshops operate a mailing business at their respective center locations. Two workshops operate off site NISH (National Industries for the Severely Handicapped) contracts while also operating NISH contracts in house. Fairfax Opportunities Unlimited operates the Pentagon Officers Athletic Club Laundry, Environmental Protection Agency mailroom, and the Department of Commerce mailroom. Sheltered Occupational Center runs a small operation preparing paper currency for printing of money at the Bureau of Printing/Engraving. In addition to the mailing businesses, Central Fairfax Services is beginning an operation of a Transitional Work Experience engaged in prime manufacturing. Mount Vernon Lee Enterprises operates a Transitional Job Training Program with work stations in industry at several locations (Days Inn, Colonial Motel, Meals on Wheels, Alexandria Hospital). Project Transition operates an individual placement program. In these vocational programs staff to client ratios range from one staff for three clients to one staff for fifteen clients, depending on the program.

In developing and providing vocational services to the mentally retarded client, strict adherence to Department of Labor Fair Labor Standards Act, Regulations 524, 525, and 529, is mandatory. All work performed by an individual must be paid to that individual according to the measured percentage of productivity as compared to a non-handicapped worker performing the same job, regardless of the level of supervision required for the handicapped worker. The rate of productivity must then be calculated according to the local prevailing wage for that activity.

For staff, parents or guardians to plan quality services they must be aware of the rules and regulations which affect a handicapped person's life. They need to be knowledgeable concerning rules and regulations of the Department of Labor, Social Security—Disabled Individual, Supplemental Security Income, and Medicaid.

Since the majority of mentally retarded clients receive SSI the need to be aware of procedures and regulations concerning benefits was an established need for service providers. Consequently, on April 5, 1983, I met with the area supervisor in Alexandria, Ms. Henrietta Woodson, and two SSI Specialists, Ms. Barbara Neds and Ms. Emilie Lurie, and requested training in SSI policies as related to the MR/DD individual in a sheltered workshop. The major premise for training involved the need to stop overpayments, establishment of a better reporting process, and education of individuals implementing a plan for cessation of SSI cash benefit eligibility.

On April 25, June 2, 9, 16, and 23, 1983 Ms. Neds or Ms. Lurie presented SSI Workshops to 153 persons in the Northern Virginia area. SSI eligibility, disability determinations, benefit computations, exclusions, benefit reductions and illustrations of SGA (Substantial Gainful Activity) were discussed. Also discussed was PASS (Plan for Achieving Self-Support) and the Section 1619 option of the Social Security Act.

The Section 1619 option had potential to greatly influence mentally retarded clients, engaging in SGA and no longer eligible for cash benefits, in that they could retain their Medicaid eligibility. This option would allow the mentally retarded worker who was producing 30 percent on some NISH contracts to have medical protection in the form of Medicaid.

In the delivery of services to mentally retarded clients in a sheltered work setting where SGA criteria has been met, the client is faced with the inability to purchase an adequate health insurance plan. To date no medical insurance coverage in the form of an individual or group health benefit package exists for the mentally retarded employees in a sheltered setting. Even NISH recognizes the lack of an employer health insurance plan for sheltered employees and therefore subsidizes each handicapped client engaged in a government NISH contract a sum of $0.32 an hour to enable an employee to save for medical expenses or to try to purchase a supplementary hospital health insuracnce plan. Unfortunately no vendor is able to provide such a plan.

Having found out that there was a possibility for continuation of Medicaid coverage, I arranged for Medicaid training with John Huppert, the senior Medicaid Trainer for the Fairfax County Department of Social Services. The purpose of the meeting was to arrange for Medicaid Training Workshops to follow up on the coordination of eligibility for services for all mentally retarded clients. The two Medicaid Trainers, John Huppert and Mary Johnson presented four Training Workshops on Medicaid eligibility requirements, services, benefits and spenddown. The Work-

shops were held on June 22, 29, July 13, and 20th, 1983. At all four Workshops the question of continued eligibility for Medicaid once SSI benefits were terminated was asked. The continuation of Medicaid coverage was discussed but no one was able to pinpoint the exact reference needed that justified this continuation.

The Joint Advocacy Coalition and the Northern Virginia ARC and the Fairfax/Falls Church Community Services Board have identified approximately 44 individuals whose SGA excluded eligibility for SSI cash payments and consequently lost their Medicaid Eligibility although they still met the criteria for eligibility according to the 1619 Regulation.

The problem does not lie in the regulations, rather it is dealing with a lack of knowledge and or coordination in knowing and implementing the existing 1619 option.

Ms. Woodson made her SSI specialists available for Training in the community. The training helped relieve overpayments, encouraged more accurate income reporting on a month by month basis, and enabled us to better do our job and advocate for our mentally retarded clients in the critical area of health insurance eligibility for Medicaid. This suggests that it might be helpful if the law encourages such sharing of information.

This problem concerning a lack of communication preventing full implementation of the benefits of the law is not a new problem. While I was in Georgia the same problems arose when SSI was established on January 1, 1974. Because of the complexities of the rules and regulations we developed an informal process for sharing information. This informal process worked so well that representation in addition to MR, MH and SA was formally sought from Social Security—Supplemental Security Income Specialists Department of Family/Childrens Services, and Department of Health, Department of Vocational Rehabilitation, to serve on the Governors Advisory Council for a seven county area known as Region V. Eligibility determination and updated information was shared monthly and problems were resolved without having to go through an appeals procedure in the majority of cases.

Please consider, ladies and gentlemen, such a solution to our problem. Employing a mechanism which facilitates communication can only benefit those clients which we all serve. You have enacted an Option—1619—which is desperately needed, so now we must educate, implement and use. Please consider recommending training programs to encourage publicity to this provision which can be of great benefit to the mentally handicapped worker. The law authorizes and should encourage publicizing the regulations for the benefit of all those concerned.

Mr. PEASE. The next witness is Merle Arnold.

STATEMENT OF MERLE ARNOLD, PRESIDENT, HOPE ENTERPRISES, INC., WILLIAMSPORT, PA., ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. ARNOLD. Yes, Mr. Chairman. I am Merle Arnold, president of Hope Enterprises of Williamsport, Pa. I appear today on behalf of the National Association of Rehabilitation Facilities, that is, NARF, of which my facility is a member. NARF is a national voluntary membership organization of community based facilities. These facilities provide comprehensive rehabilitation services to over 400,000 disabled people each year. Many of these people are social security disability insurance and supplemental security income beneficiaries.

For example, in my own facility, we provide vocational training, work adjustment training, long-term sheltered employment work activities and, in our case, adult day care. In a recent month we provided services to 227 handicapped persons. Of those 227, 48 of them are receiving SSDI, and 85 are receiving SSI benefits. That means about 60 percent of those persons are benefitting from these two programs.

NARF believes that public policy should be focused on placing the maximum number of people in competitive employment. However, we acknowledge there are large numbers of severely disabled

people who are unlikely to achieve such placement but who many benefit financially and otherwise from supervised employment in the community or in sheltered employment.

With respect to the SSI program, we have historically supported changes which provide incentives to help beneficiaries become self-sufficient, but not through a system that eliminates benefits to do so. In view of this, my testimony focuses on ways to continue and increase such incentives. The Disability Amendments of 1980 went a long way to create new incentives for beneficiaries to obtain and maintain employment.

One of these incentives, referred to as the special SSI benefits program under section 1619, is authorized to December 1983. This program allows SSI beneficiaries who earn above SGA despite a continuing disabling condition, to continue to receive special cash benefits. I will skip down and hurry along.

Medicaid and social services, of course, would also continue. In certain circumstances, when the special cash benefits would end, medical and social services would continue. Prior to this provision, when people were engaged in SGA, they lost their eligibility for cash benefits as well as medical and other benefits. This acted as a disincentive to continuing to work and earning money.

As the president of a facility, I have personally received phone calls from a parent indicating they want to withdraw their son or daughter from a particular work program we are providing because they are about to exceed or may exceed the SGA level. The parents are calling to say they do not want their child to lose their benefits. They also make it clear they are not aware of any way in which those benefits can be continued. They do not seem to be aware of the 1619 program we have heard so much about today.

In discussion with my own staff, I find they also are unaware of the program, and they are in the trenches every day, not only in our vocational facility but in our residential program. In fact, they said in their experience with SSA, SSA does not advise them of this program or the vocational rehabilitation program which I will mention later. So, as a facility, you have to know this program exists in order to ask about it.

Additionally, my staff indicated they are experiencing people being reviewed by SSA and having benefits terminated after 2 months of SGA when the minimum trial period, as we know, is 9 months. I have to express my amazement. This program offers excellent incentives for clients to continue to work. It also allows facilities to be able to continue rehabilitation service plans without interruption. Interruptions in services require some repetition to bring the client back to the level he or she was at at the time they may have left. It also offers incentives to parents and families to support their adult children in employment and independent efforts. Why is it so complex? If this were a clear-cut program, why do not people who work with it daily know about its availability?

I understand your bill, H.R. 2354, would make this program permanent, and we support this proposal based on our experience. Not only do clients benefit, but savings accrue to the Government in the form of fewer benefits paid out either through removal from the rolls or proportionate reductions. We also suggest your commit-

tee urge the Department of Health and Human Services to make certain it is made known nationwide.

The vocational rehabilitation program for SSI and SSDI beneficiaries also needs to be reexamined. The history of the program is outlined in my written testimony. It was amended by the Omnibus Budget Reconciliation Act of 1981. As amended, it will pay for services resulting in successful rehabilitation only. A successful rehabilitation is defined as a person performing substantial gainful activity for 9 continuous months. The purpose of the beneficiary vocational rehabilitation program is to return people to work, thereby resulting in a savings to the trust fund. All studies of the program show it to be cost effective.

The Omnibus Budget Reconciliation Act of 1981 amended the beneficary vocational rehabilitation program for SSI and SSDI beneficiaries. The bill currently being considered by the Social Security Subcommittee would amend the program to allow payment in two additional circumstances, in the event of medical recovery and when a person refuses without good cause to cooperate. These changes are helpful, but do not address the problem of covering costs for delivering services to unsuccessful rehabilitations.

It is imprudent for facilities to take referrals if they must pay the cost whether or not the rehabilitation is successful unless there is a financial incentive to participate. Otherwise, they will always be losing funds.

I would simply like to make a side remark. I do not think this has been adequately looked to in all of the testimony I was able to hear this morning.

Second, one standard for referral is the likelihood that rehabilitation services will result in placement in competitive employment, and the person will no longer require cash benefits. According to a recent study done by the State of Michigan, the composition of the SSI disabled population is considerably different than that of the SSDI population. They are younger, female, and have more mental disabilities and little work experience. This group may not be able to work in competitive employment, but rehabilitation services will help them do some work and reduce the need for and amount of benefits, and we can provide more documentation of that.

We recommend the vocational rehabilitation program be amended to provide a financial incentive for providers to participate. This incentive would be in the form of a premium over the cost for services. Second, placement in competitive employment should not be the only standard for referral. Placement in sheltered employment or placement in competitive employment with supportive services with accompanying reduction in benefits due to earnings should also be considered a basis for referral and payment for services.

Finally, the 1980 amendments gave SSA the authority to conduct demonstration projects on the effects of earlier referral for rehabilitation and the greater use of provider organizations to perform or stimulate new forms of rehabilitation. To date these projects have not been conducted. Perhaps those projects should be acted on before any new demonstration projects come up.

Our third recommendation pertaining to direct referral of clients to rehabilitation facilities and case management by such facilities is stated in our written testimony. Therefore, I would simply call

your attention to that, abbreviate my statement, and thank you for this opportunity to testify.

[The prepared statement follows:]

STATEMENT OF MERLE ARNOLD, PRESIDENT, HOPE ENTERPRISES, INC., WILLIAMSPORT, PA., ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

SUMMARY

Public policy should be focused on maximum placement of disabled people in competitive employment. Many disabled people may not achieve such placement, but may benefit from sheltered employment. NARF supports changes in the SSDI and SSI program to provide incentives for beneficiaries to become self sufficient.

I. Continued special SSI benefits

The Social Security Disability Amendments of 1980 added incentives for employment for SSDI and SSI beneficiaries. One of these was the special cash benefits program under Section 1619 which allows people who can engage in substantial gainful activity to receive special cash benefits. Even when these special cash benefits end, some people may continue to be eligible for Medicaid and other services if ending benefits would impair their ability to continue to work and if they cannot purchase equivalent benefits. The provision is effective only through December 31, 1983.

This program provides SSI disabled recipients every incentive to seek employment in spite of a disabling condition, without the fear that all income will be lost on reaching the substantial gainful activity level nor that all supportive medical and social services will be lost. Savings would accrue in the form of fewer benefits paid. Section 301 of H.R. 2354 would make it a permanent program.

Recommendation.—We support Section 301 of H.R. 2354.

II. Beneficiary vocational rehabilitation program

This purpose of the beneficiary vocational rehabilitation program is to return people to work, thereby resulting in savings to the trust fund. In 1981 $124 million was available for both SSI and SSDI beneficiaries and approximately 150,000 people were served. All studies of the program show it to be cost effective. The Omnibus Budget Reconciliation Act of 1981 amended the program.

The new provision provides that states will be paid only for successful rehabilitations. A successful rehabilitation is defined as a person performing substantial gainful activity for nine continuous months. States and facilities have very little financial incentive to participate. The bill currently being considered by the Social Security Subcommittee would amend the program to allow payment in two additional circumstances: in the event of medical recovery and when a person refuses without good cause to cooperate. These changes are helpful but do not address the problem of covering costs for delivering services to unsuccessful rehabilitations. It is imprudent for facilities to take referrals if they must pay the cost whether or not the rehabilitation is successful, unless there is a financial incentive to participate.

One standard for referral is rehabilitation to placement in competitive employment and no longer requiring cash benefits. The SSI disabled population is younger, female, has more mental disabilities, and less work experience than the SSDI population. This group may not be able to work in a competitive employment—but rehabilitation services will help them do some work and reduce the need for, and amount of, benefits.

Recommendation.—The vocational rehabilitation program should be amended to provide a financial incentive for providers to participate. This incentive should be in the form of a premium over the cost for services. Second, placement in competitive employment should not be the only standard for referral. Placement in sheltered employment or placement in competitive employment with supportive services with a concomitant reduction in benefits due to earnings should also be considered a basis for referral and payment for service.

III. Referral and case management

The 1980 amendments gave SSA the authority to conduct demonstration projects on the effects of earlier referral for rehabilitation and the greater use of provider organizations to perform or stimulate new forms of rehabilitation. To date these projects have not been conducted.

Referrals for rehabilitation services are not made until months after the disabling condition occurs. Delay in referral and receipt of services may compound the severity of the disability.

Recommendation.—When an applicant or beneficiary applies for a disability determination or services, a direct referral should be made to a public or private nonprofit organization for work evaluation, evaluation of vocational potential, developing a services plan, delivery of rehabilitation services and case management. Facilities have the experience and expertise to deliver these services.

While some of these recommendations may require expenditures, in both the short and the long run, the overall result is savings—in the form of fewer benefits and immeasurable personal savings in the form of personal independence.

STATEMENT

Mr. Chairman: My name is Merle Arnold. I am President of Hope Enterprises, Inc. of Williamsport, Pennsylvania. I am appearing today on behalf of the National Association of Rehabilitation Facilities (NARF), of which my facility is a member. NARF is the national voluntary membership organization of community based rehabilitation facilities. These facilities provide comprehensive rehabilitation services to over 400,000 disabled people each year. Many of these people are social security disability insurance and supplemental security income beneficiaries.

NARF's position is that public policy should be focused on maximum placement of disabled people in competitive employment. However, there are large numbers of severely disabled people who are unlikely to achieve such placements but who may benefit, financially and otherwise, from supervised employment in the community or sheltered employment designed to utilize their abilities. With respect to the SSI and SSDI programs, we have historically supported changes in the programs which provide incentives to help beneficiaries become self sufficient, but not through a system that eliminates benefits to do so. In view of this position I will focus my testimony on continuation and improvement of such incentives.

I. Special cash benefits

The Social Security Disability Amendments of 1980 included several provisions which broadened opportunities for disabled people to return to gainful employment and incentives to do so. These included eliminating the second Medicare waiting period for SSDI beneficiaries, continuing Medicare benefits for an additional 36 months after cash benefits ended under SSDI; counting wages from sheltered workshop employment as earned income and allowing extraordinary work expenses to be deducted from the earnings of beneficiaries for determining substantial gainful activity.

Another provision allows people who are able to engage in SGA to be eligible for special cash benefits under Section 1619. They may continue to receive cash benefits equivalent to those under the regular SSI program and continue to receive Medicaid and social services on the same basis as nondisabled SSI recipients. Cash benefits cease when the person's earnings equal the amount that would cause federal SSI payments to stop, referred to as "the breakeven point." However, Medicaid and social services may continue if the Secretary finds ending these benefits would impair a client's ability to continue to be employed and if he cannot purchase equivalent private health insurance and other services. This provision is effective only through December 31, 1983.

This program gives SSI disabled recipients every incentive to seek employment whether or not the disabling condition continues. It provides a safety net of continued benefits and the medical and social services a disabled person often needs to obtain and maintain a job, whether it is in competitive employment or a sheltered workshop.

In both the long and short run, it lessens the total amount of cash benefits paid out because people either terminate all three kinds of benefits, a percentage of cash benefits, all cash benefits and/or portions of medical and social services. Hence, people would not remain totally dependent financially, medically and socially.

We support section 301 of H.R. 2354 to continue this program. We also recommend to the Committee that it encourage the Department of Health and Human Services to be more vigorous in its implementation of the provision. While most workshop managers may be aware of the provision, the local SSI offices have not made its existence or operation well know.

II. Vocational rehabilitation program

Prior to the Omnibus Budget Reconciliation Act of 1981, the beneficiary vocational rehabilitation program authorized funds to be paid to states agencies for services delivered to SSDI and SSI beneficiaries. The purpose of the program was to return them to work, thereby resulting in savings to the trust fund. In 1981, $124 million

was available for both SSI and SSDI beneficiaries and approximately 150,000 people were served. All studies of the program have shown it to be cost effective.

The Omnibus Budget Reconciliation Act of 1981 amended the program and, in our opinion, rendered it almost useless. The new provision provides that states are to be paid either in advance or by way of reimbursement for successful rehabilitation. A successful rehabilitation is defined as a person performing substantial gainful activity for nine continuous months.

It has been our experience that since the program has been amended, states and others have very little incentive to participate in it. The Administration has not made sufficient funding available. Only $6 million was requested last year, and the same amount is proposed for fiscal 1984. Second, states and facilities are paid only on the basis of successful rehabilitations. The assumption appears to have been that states are expected to use funds under Title I of the Rehabilitation Act to provide these services. These two programs address different parts of the total disable population. Title I of the Rehabilitation Act is formulated to serve all disabled individuals who are referred to state agencies with a priority that state agencies serve the more severely disabled. People served under the beneficiary rehabilitation program are those who have been determined to be able to benefit from a vocational rehabilitation program, regain the ability to work, and will no longer require benefits. Usually this population is not the more severely disable client. Given the virtual elimination of the program and little increase in funds under the Rehabilitation Act, many states are turning clients away.

I understand that the Social Security Disability Benefits Reform Act of 1983 currently being considered by the Social Security Subcommittee would amend this program to allow payments in two additional circumstances: in the event of medical recovery and in cases where the person refuses without good cause to accept services or fails to cooperate. It would also require the proposed Advisory Council to examine the entire rehabilitation program and report back to the Secretary with recommendations on how to improve the program.

While these changes will be very helpful in expanding the circumstances for which services would be paid, they leave open the question of covering the cost of delivering services for unsuccessful rehabilitations. If the program is going to reimburse facilities or states only for the services outlined above, both facilities and states will be at risk for good faith efforts to rehabilitate beneficiaries that do not result in a successful rehabilitation. While agencies may use the basic state grant funds, such funds would then be depleted for other clients. Facilities, however, would have to pay for funds for services out of their own capital, which means they would be decreasing their service capacity. We believe it would be imprudent for the facility to accept referrals if they must pay the cost whether or not the rehabilitation was successful, unless there is an incentive for a financial payment commensurate with the risk. Even the best evaluation techniques do not guarantee one hundred percent success. If the cost paid is for successful rehabilitations, and none for unsuccessful ones, the facility can, at best, only come out even. Actually, they will always be losing funds.

If facilities accept such referrals and the risk of nonsuccessful rehabilitations, we recommend that there should be an incentive and reward for doing so. This incentive should be a payment in the form of a premium over the cost of services. We make this recommendation acknowledging that the payment for unsuccessful rehabilitations would be zero.

Second, the subcommittee may wish to examine closely the nature of the disabled SSI population and the differences from the SSDI population. According to a report conducted by the State government in Michigan a higher percentage of the SSI population does not have an extensive employment history prior to the disability, a higher percentage is female and, as compared to the SSDI population, 24 percent vs. 7 percent are under 30. And, speaking for my own facility, increasing numbers of these people are suffering from a mental disability which may preclude their working in a competitive environment independent of supportive services.

I raise this point because currently people are referred for services only if they are considered to be able to be fully rehabilitated off the rolls and placed in competitive employment. This is part of the successful rehabilitation standard. Those people who benefit from services, but do not obtain economic independence, and no longer need the special medical and social services mentioned above, are generally not referred to this program. However, for these people there may still be a net savings for the SSI program if the services result in the person reaching his or her maximum functional level and income. We recommend that the current standard for a successful rehabilitation which requires placement in competitive employment be revised to allow placement other than in competitive employment which results

in fewer benefits paid to be part of the definition of a successful rehabilitation and therefore payment for services.

III. Referral and case management

The 1980 amendments authorized the Social Security Administration to conduct demonstration projects regarding the effects of earlier referral of beneficiaries for rehabilitation and greater use of provider organizations to perform or stimulate new forms of rehabilitation. While it has been considering and drafting a request for proposal to conduct this demonstration, SSA has not done so to date. The 1980 amendments require the Secretary to submit a report by 1985—only two years away.

Given the nature of the disability determination process, a beneficiary is not referred for rehabilitation services until many weeks or months after the onset of the disability. First the state disability determination office must make a determination of disability. This is done, at least for SSDI applicants, after the five month waiting period has expired. At the same time the disability determination is made, the state DDS office will consider whether the person has vocational rehabilitation potential. If according to HHS criteria the state DDS office feels the person will be rehabilitated his is referred to a state vocational counselor. If the person doesn't get lost in the paper shuffle, the vocational counselor will conduct an evaluation and eventually refer the person for a program of services. In certain cases this delay in referral and receipt of services may actually compound the severity of the disability.

During consideration of the 1980 amendments, NARF urged that the vocational program be amended to allow direct referral of beneficiaries to public and private nonprofit organizations for evaluation of rehabilitation potential and delivery of services as early as possible during the disability process. An evaluation should occur at the time of the initial contact with the district SSA office. Interim rehabilitation services should be delivered during the waiting period to the determination of a disability, thereby improving the prospect for a successful rehabilitation. We urge the committee to provide for direct referral to public and private organizations at the time of application for disability.

Second, we recommend that in addition to direct referral that district SSA offices be allowed to contract with local, public and private nonprofit organizations to provide service plan development and case management of applicants and beneficiaries. Services to be provided by such organizations, including rehabilitation facilities, would include work evaluations, planning and managing beneficiaries receiving services and tracking the progress of those who are working during a trial period and while receiving special benefits. Rehabilitation facilities have considerable experience and expertise in case management and evaluation.

Mr. Chairman, these are our impressions of what can be done to help disabled SSI beneficiaries be self-sufficient. As a society we should never give up on anyone and leave them in a dependent state and without any hope for improvement or negate it with complex and conflicting programs. While some of these recommendations require expenditures, in both the long and short run the overall result is savings—savings in the form of fewer benefits paid out and immeasurable personal savings in the form of personal independence.

Mr. PEASE. Thank you, Mr. Arnold. Thank you very much.

Mr. Manes, you may proceed.

STATEMENT OF JOSEPH MANES, SENIOR POLICY ANALYST, MENTAL HEALTH LAW PROJECT, ALSO APPEARING ON BEHALF OF THE NATIONAL SENIOR CITIZENS LAW CENTER

Mr. MANES. Mr. Chairman, I am Joseph Manes. I am with the Mental Health Law Project. I appear today on behalf of the Mental Health Law Project and the National Senior Citizens Law Center, to testify before the committee. I have prepared a written statement which I would like to have made part of the record, and I will summarize a few of the major points I make in the statement.

Mr. PEASE. That is fine.

Mr. MANES. Generally, we maintain that the bill introduced by Mr. Shannon and Mr. Stark, H.R. 2987, addresses the problems that have been identified in the social security disability insurance system and should be applied also to the supplemental security

income program. That legislation represents the considered opinion of organizations such as ours as well as religious women, elderly, and labor organizations.

We recommend the Public Assistance Subcommittee seriously consider the provisions of that bill now being marked up by the Social Security Subcommittee.

I would like to deal with just a couple of major areas dealt with in the Shannon-Stark bill, primarily the evaluation of mentally impaired persons, and how their ability to work is assessed. The mental health law project has brought several cases against the Social Security Administration, and has been successful in securing court rulings that have held that the Social Security Administration has not properly assessed the ability of mentally impaired persons to work.

In the case of the *Mental Health Association of Minnesota* v. *Schweicker,* which was decided last December, the court ruled that SSA has, and I quote, "No medical, vocational, or other empirical or scientific basis for presuming that a mentally impaired person whose condition does not meet or equal the listings retains the residual functioning capacity to work."

The court then issued a far-reaching injunction applicable to the six States in the Chicago region of HHS against continued application of the presumption, that had been administratively applied, that persons who do not meet the listings are automatically assumed to be able to do at least unskilled work.

The court ordered SSA to restore benefits to all mentally impaired persons who were adversely affected by this presumption since March 1981, and to reevaluate their eligibility under the continuing disability investigations that SSA is conducting under the 1980 statute. Up to now the CDI's have been primarily applied to the disability insurance population, of which we estimate 10 to 15 percent are mentally impaired.

Except for concurrent beneficiaries, those who receive both SSI and DI, the CDI's have not been applied to the SSI population. Of that population, we estimate and Mr. Simmons confirmed this morning, that about one-third have mental impairments. Therefore, this is the proper time to correct the procedure that SSA has been engaged in under the DI program before we get a repetition in SSI of the human misery that became apparent last year when the CDI, under the DI program were fully applied.

We believe the only way the proper sequential review for mentally impaired persons can be fully realized is through legislation. We have no confidence that SSA can make the necessary changes administratively to achieve a complete assessment of ability to work for mentally impaired persons. H.R. 2987 contains several provisions to achieve this objective.

Section 104 requires a work evaluation at an actual or simulated worksite as an integral part of the review of ability to work. We endorse that provision. Section 105 of the Shannon-Stark bill prohibits the practice of improperly equating the capacity to do sheltered work with the ability to hold a competitive job. Section 204 would require SSA to do a complete medical and vocational history of the applicant, including reviewing all evidence in the file from prior evaluations. In situations of long-term illnesses, particularly

chronic mental illness which often follows an erratic course, SSA has mistakenly accepted temporary improvement as representing an end to the disability.

At the present time in the markup in the Social Security Subcommittee these three sections have been relegated to report language. We would urge that they be put into statutory language as provided for in the Shannon-Stark bill, H.R. 2987.

Another issue I would like to mention involves SSA's policy of nonacquiescing in the opinions of circuit courts of appeals. SSA will follow a circuit court of appeals decision as it applies to the individuals named in the case, but will not apply the rule of the circuit to their administrative practices. SSA issues a formal statement of nonacquiescence in which it states that it will not follow the court order and puts that out as a public statement.

At least four courts have considered this issue and have ruled SSA's practice of nonacquiescence to be objectionable. They have all said SSA is bound to follow the law of the circuit.

In the most recent case, *Lopez* v. *Heckler,* in June 1983, the court stated: "For the Secretary to make the general assertion that a decision of the court of appeals is not to be followed because she disagrees with it is to operate outside the law." As a result of the court's order, approximately 72,000 individuals terminated under the SSDI and SSI who reside in the ninth circuit are now entitled to have their cases redetermined as it applies to medical improvement as enunciated in two earlier circuit court cases, *Finnegan* v. *Matthews* in 1981 and *Patti* v. *Schweicker* in 1982.

We believe that a statutory prohibition on SSA's nonacquiescence policy is critical. We cannot wait for the courts one by one to find their nonacquiescence policy objectionable. Without it, SSA will continue to hold itself above the law. In the markup of the Social Security Subcommittee, there is statutory language that provides that SSA will be required to acquiesce in cases decided by the courts of appeals, but those cases decided only after the effective date of the bill, in other words, prospective acquiescence.

While this will be helpful in the future, it would be much more helpful if a bill required SSA to also acquiesce in prior decisions, past decisions of the circuit court which affect a number of very important issues that affect disabled persons. The evaluation of pain, alcoholism, obesity, the weight to be accorded to a treating physician's report, and the ALJ's obligation to assist unrepresented claimants, in all those instances there have been circuit court opinions which SSA has nonacquiesced in. We would urge that the acquiescence provision be made to apply to those prior decisions.

The rest of my statement is available for your staff's consideration. I thank you for the opportunity to testify.

[The prepared statement of Mr. Manes follows:]

JOINT STATEMENT OF JOSEPH MANES OF THE MENTAL HEALTH LAW PROJECT, AND EILEEN P. SWEENEY OF THE NATIONAL SENIOR CITIZENS LAW CENTER

I am Joseph Manes, senior policy analyst at the Mental Helath Law Project, appearing today for myself and Eileen Sweeney, staff attorney at the National Senior Citizens Law Center, at the written invitation of this Subcommittee. We are most appreciative of the opportunity to appear before the Subcommittee today and to submit written testimony.

The Mental Health Law Project is a not-for-profit public interest organization that represents mentally ill and developmentally disabled persons and those so labeled. The Project is primarily funded through foundation grants and invidual contributions. We are also a back-up center for the Legal Services Corporation working with legal services attorneys on the Social Security and SSI problems of their mentally disabled clients.

The National Senior Citizens Law Center (NSCLC) is a national support center, specializing in the legal problems of elderly poor people. NSCLC is funded by the Legal Services Corporation and provides support services to legal services attorneys throughout the country with respect to the legal problems of their elderly and disabled clients. NSCLC responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

Our testimony will focus on (1) a number of issues related to standards utilized by SSA in assessing disability and to procedural problems which have arisen; and (2) our recommendations for steps which this Subcommittee should take to amend the Title II disability bill currently being marked-up by the Social Security Subcommittee.

In reviewing the issues set forth below, three underlying factors should be noted. First, with the exception of the medical improvement standard and the availability of aid pending appeal, the problems for new applicants are identical to those of recipients subjected to the CDIs. Second, the problems of the physically impaired with the system, particularly those with multiple impairments, cardiac conditions, and back problems are no less severe than those faced by the mentally impaired. Third, the changes recommended are applicable to both the SSI and OASDI programs. SSA is already terminating significant numbers of non-concurrent SSI beneficiaries as well as concurrent beneficiaries under CDI review.

Finally, we believe that H.R. 2987, introduced by Representatives Shannon and Stark, represents a well-thought-out package of reforms and improvements in the disability determination process. It represents the considered opinion of organizations representing the disabled and has received the endorsement of a wide range of religious, women's, elderly and labor organizations. We recommend that the Committee bill on OASDI and SSI issues retain the provisions included in H.R. 2987.

The need for legislative action in this area has not diminished. The changes announced by Secretary Heckler in June 1, 1983 emphasize, rather than mitigate, this need.

I. THE STANDARDS UTILIZED BY SSA IN EVALUATING DISABILITY SHOULD BE CHANGED

In our experience, there are essentially five problems in the area of standards which currently are creating the greatest hardships for disabled beneficiaries and applicants:

A. SSA's insistence on terminating benefits despite the fact that there is no evidence of medical improvement;

B. SSA's failure to consider vocational factors in assessing whether an impairment is severe;

C. SSA's refusal in many cases to consider the combined effects of multiple impairments;

D. SSA's failure to consider the existence of pain and the effect which debilitating pain has upon the ability to perform substantial gainful activity; and

E. SSA's failure to properly evaluate the impairments and limitations of mentally disabled individuals.

A. SSA should be required to continue benefits unless there is evidence of medical improvement or that the original decision was clearly erroneous

Numerous courts have recently ruled against SSA's current policy and have required SSA to have evidence of medical improvement or that the original decision was clearly erroneous before disability benefits can be terminated.[1] This has been the ruling in SSI, SSI "grandfathered," and Title II worker's disability cases. Other courts have ruled that once a person has been found to be disabled, there is a presumption that he/she remains disabled and that SSA has the burden of proving

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[1] See, for example, *Finnegan* v. *Mathews*, 641 F.2d 1340 (9th Cir. 1981); *Simpson* v. *Schweiker*, 691 F.2d 966 (11th Cir. 1982); *Musgrove* v. *Schweiker*, 552 F.Supp. 104 (E.D. Pa. 1982); *Singleton* v. *Schweiker*, 551 F.Supp. 715 (E.D. Pa. 1982); *Shaw* v. *Schweiker* 536 F.Supp. 79 (E.D. Pa. 1982); *DeVault* v. *Schweiker*, Civ. Action No. 81-0070-C (N.D. W.Va. 1982); *Dudley* v. *Schweiker*, Civ. Action No. 81-0004-C (N.D. W.Va. 1982).

that he/she is no longer disabled.[2] SSA has issued "ruling of non-acquiescence" in at least two of these cases, *Patti* and *Finegan*.[3]

It is worth noting that SSA already applies the "medical improvement" analysis in two contexts. First, SSA applies the "medical improvement" test in determining that any individual whose impairment is on the list of "permanent disabilities" (and is thus exempt from CDI review) will be reviewed despite the exemption. Second, the notion of "medical improvement" is the basis for SSA's system of "diarying" cases for reviews. If SSA staff believe that an individual's condition is likely to improve, his/her case will be "diaried" for a particular time, at which a review will take place. In other words, SSA utilizes the concept of medical improvement when it is likely not to be beneficial to recipients (in terms of continuation of their benefits), but not when it could assist the recipient to retain eligibility. More importantly, SSA is familiar with the concept and not only knows how to use it, but is currently using it.[4]

The numerous court decisions and SSA's own current use of the medical improvement standard raise serious questions about SSA's alleged need to study the issue further (as proposed by Secretary Heckler) while depriving individuals being subjected to the CDIs of the benefit of the standard.

We believed that the "clear and convincing" evidence standard set forth in § 101 of H.R. 2987 is the appropriate standard of review in these cases. It generally requires that the government assume a higher level of risk than would be required with a "preponderance of the evidence" standard. In the context of assuring accurate decisionmaking where disabled individuals at least once previously have been determined to be disabled by SSA, it is desirable to require that this intermediate level of proof be required.[5]

B. and C. SSA should be required to consider vocational factors and the combined effect of all impairments in assessing severity of impairment

In 1982, SSA denied or terminated 40.2 percent of the Title II disability cases it adjudicated on the basis of a "slight" (read "non-severe") impairment.[6] In 1981, the figure was even higher: 45.2 percent.[7] The figures for SSI are likely to be comparable or, if possible, higher.

These high figures are only possible for two reasons: 1. SSA fails to consider vocational factors in assessing severity of impairment. 2. SSA refuses to consider the combined effects of "non-severe" impairments in assessing severity.

Each issue is discussed below.

1. *SSA fails to consider vocational factors in assessing severity of impairment.*— Under SSA's sequential evaluation, the finding of non-severity is wholly medical; no consideration is given to the vocational factors (age, education and work experience). See 20 C.F.R. § 404.1520(c). SSA has taken the position that this is as the Congress intended, that there must be a solely medical assessment initially. Further, SSA claims that it would be extremely burdensome for it to have to perform vocational assessments where the person only has a "stubbed toe."

42 U.S.C. § 1382c(a)(3)(B) provides that in order to be eligible to receive SSI, a person "shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his

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[2] See, for example, *Patti* v. *Schweiker*, 669 F.2d 582 (9th Cir. 1982); *Luke* v. *Schweiker*, CCH Unemp. Ins. Rptr. ¶ 17,933(c) (D. Miss. 1981).

[3] Social Security Rulings 82-10c (*Finnegan*) and 82-49c (*Patti*). The issue of SSA's non-acquiescence is discussed, infra, at pp. 19–23.

[4] And, before 1976, applied it regularly in all cases.

[5] Further, SSA already has familiarity with the "clear and convincing" evidence standard in evaluating the eligibility of an illegitimate child to receive benefits on the account of a deceased wage-earner parent. 42 U.S.C. § 416(h)(2)(A) provides that children who would be entitled to inherit from the wage-earner parent under state intestacy laws are deemed to be dependent and eligible to receive benefits. In that context, SSA staff regularly apply many state intestacy laws which have been modeled on the Uniform Probate Code (UPC). The UPC provides for interitance where there is "clear and convincing" evidence of paternity. In that context, SSA has provided its staff with the following description of the standard: Generally, the evidentiary standard of "clear and convincing proof" or "clear and convincing evidence" is an intermediate standard, requiring more certainty on the part of the fact finder that a "preponderance of the evidence standard, but less certainty then the "beyond a reasonable doubt" standard historically reserved for use in a criminal case. POMS § T00306.125, "Evidentiary Standards Under State Intestacy Laws"

[6] "Background Material and Data on Major Programs Within the Jurisdiction of the Committee on Ways and Means," Committee on Ways and Means, U.S. House of Representatives, WMCP: 98-2, p. 79 (February 8, 1983).

[7] *Id.*

previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy . . ." Here, the "severity" standard incorporates both the medical and vocational factors. Identical language is provided in Title II, 42 U.S.C. § 423(d)(2)(A). In the last couple years, there have been many court decisions upholding SSA's determination that the claimant did not have a severe impairment. However, it should be noted that it does not appear that the plaintiffs challenged the validity of SSA's "non-severe" step. In *Scruggs* v. *Schweiker*, 559 F. Supp. 100, 103 (M.D. Tenn. 1983), the court held that SSA could not separate out the medical from the vocational:

". . . Thus, it appears that Congress fully intended that the severity of clinically established impairments be considered in relation to the vocational prospects of the individual. A non-severe finding, with nothing more, does not comply with this statutory requirement."

The *Scruggs* decision addressed both Titles II and XVI (SSI). 559 F. Supp. at 102.

SSA has itself wholly undermined its "stubbed toe" analysis, effectively eliminating it as a basis for concern. In *Lofton* v. *Schweiker*, 653 F. 2d 215, 217–218, n. 1 (5th Cir. 1981), the Court refers to SSA's introduction to the 1979 regulations which included the sequential evaluation process:

". . . The Secretary observed that: 'In most cases that involve an impairment that is not severe, the vocational evaluation guides can be applied as efficiently as can the nonsevere impairment principle. Most cases of this kind do not require extensive investigation of a person's vocational background in order to evaluate them under the vocational guidelines. We can decide many cases of this type on the basis that a person can return to his or her most recent occupation.' The Secretary is currently studying the feasibility of revising this regulation."

Of course, the burden is on the disabled individual to prove that he/she cannot perform his/her past relevant work. It is not until after that step that the burden shifts to SSA. As a result, the cost of properly including a vocational assessment is low, while assuring that those entitled to receive full vocational assessments receive them. SSA said "most," not all, would be picked up at the past relevant work stage. The others are entitled by statute to a full vocational assessment.

The cost figures of SSA's actuary, provided to the Social Security Subcommittee and dated July 27, 1983, indicate that the "majority of the cost" of Section 101 of the Subcommittee's draft bill, addressing standards of review in termination cases, "results from report language which requires the evaluation of work ability in all initial and review cases where an impairment exists." (footnote 2) Given SSA's statements in *Lofton* that most of the individuals would be denied at the past-relevant-work step, it is difficult to understand the basis for the actuary's estimate. It would be useful if this Subcommittee would question the underlying assumptions for this and other cost estimates made for the Social Security Subcommittee's bill.

2. SSA refuses to consider the combined affects of "non-severe" impairments in assessing severity.—SSA has taken the position that it will not combine the effects of "non-severe" impairments in assessing severity. In Social Security Ruling No. 82–55, SSA stated:

"Inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs. However, when a nonsevere impairment(s) is imposed upon a severe impairment(s), the combined effect of all impairments must be considered in assessing RFC."

SSA's own regulation is even worse. 20 C.F.R. § 404.1522 provides that SSA "will consider the combined effects of unrelated impairments only if all are severe and expected to last 12 months." [8]

The result of the application of either 20 C.F.R. § 404.1522 or Social Security Ruling No. 82–55 is that many severely disabled individuals are being denied benefits or having their benefits terminated because SSA fails to acknowledge the existence of some or all of their impairments and fails to consider the impact of these impairments upon their ability to engage in substantial gainful activity.

Section 102 of H.R. 2987 addresses this problem well. It simply requires the Secretary to consider the combined effect of all impairments in assessing severity. It does not in anyway modify the disability test set forth in the statute but assures that all disabled individuals will receive full and fair consideration of the effects of all of

[8] While SSR 82–55 can be read as a liberalization of the regulation, the content of SSR 82–55 has been SSA's policy for some time. This presents an excellent example of a situation where SSA should have utilized the public notice and comment procedures of the Administrative Procedure Act. Had it done so, it might have developed a policy very different from the current policy which excludes consideration of numerous impairments.

their impairments. At this point, the combination of impairments language has been relegated to Committee Report language. We believe that this language should be returned to the actual bill, as had been done in H.R. 2987.

D. SSA should be required to consider all evidence of the existence and degree of pain

"Pain" is a concept foreign to SSA. While it is discussed in SSA's regulations, it has been stripped of its meaning and categorized to the point where it no longer exists as a factor to be considered in most, if not all, disability evaluations. For example, in Social Security Ruling 82-55, SSA identified a number of impairments which it has determined to be "non-severe." In doing so, SSA stated that it had presumed a level of pain for each condition: "In formulating these examples, the potential for severe and prolonged pain has been considered. These conditions are not expected to produce severe and prolonged pain."

In other words, even if a person suffered from far greater pain, SSA would ignore his/her proof of this fact.

Further, in Social Security Ruling 82-58, SSA limited the consideration of pain further than that set forth in its own regulations. 20 C.F.R. § 404.1529 provides:

"If you have a physical or mental impairment, you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain, and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs or findings show that there is a medical condition that could be reasonably expected to produce those symptoms."

Despite that language, stating that SSA will consider pain if there is evidence of "a medical condition that could be reasonably expected to produce those symptoms," SSA added an extra test in SSR 82-58:

"Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported. However, once such a medical condition (e.g., disc disease) is objectively established, the symptoms are still not controlling for purposes of evaluating disability. Clincial and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment. Objective clinical findings which can be used to draw reasonable conclusions about the validity of the intensity and persistence of symptoms and about its effect on the individual's work capacity must be present. For example, in cases of back pain associated with disc disease, typical associated findings are muscle spasm, sensory loss, motor loss and atrophy. There must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom."

In NSCLC's testimony before the Social Security Subcommittee in October 1981, a number of cases were discussed in detail where a restrictive definition of pain would result in seriously disabled individuals being denied benefits.[9] SSA has essentially adopted that extremely restrictive approach in its ruling.[10]

The Social Security Subcommittee has, at this point, decided that SSA should be mandated to study the issue of pain. This was done, in part, with an understanding that SSA would meanwhile be required to follow the Circuit Court of Appeals decisions on pain, which are often more in line with the approach taken in H.R. 2987. However, because it appears that that Subcommittee may not require SSA, by statute, to follow court decisions decided before enactment of the bill, it is possible that even claimants and recipients in circuits with good law on the pain issue will not benefit from it.

E. SSA has not properly evaluated the impairments and limitations of mentally disabled individuals

Our testimony here is based upon MHLP's experience as counsel for the plaintiffs in three class actions in Minnesota, Utah, and New York. These cases involve challenges to the Social Security Adminstration's termination from the disability rolls of mentally disabled recipients. In the case of *Mental Health Association of Minnesota*

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[9] "Social Security Appeals and Case Review Process," Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, Serial 97-31, pp. 203-205.

[10] Again, without the benefit of public notice and comment.

v. *Schweiker*, 554 F. Supp. 157 (D. Minn. 1982), a federal district court has ordered SSA to revise its standards for determining mental disability and re-evaluate all cases of denial or termination of benefits to mentally disabled persons. The other two cases are in earlier stages of litigation.

MHLP's research in these cases has consistently demonstrated that the Social Security Adminstration short-circuits the Social Security Act and its regulations during the conduct of continuing disability investigations. SSA has communicated a new standard to its regional offices and state agencies: mentally impaired claimants under the age of 50 who did not meet SSA's "Listing of Impairments" were presumed capable of at least unskilled work. This presumption almost invariably resulted in denial of disability benefits. In its preliminary ruling in *Mental Health Associaiton of Minnesota* v. *Schweiker*, the court found that "SSA has no medical, vocational or other empirical or scientific basis for presuming that a mentally impaired person whose condition does not meet or equal to the Listing retains the residual functional capacity to work." The court issued a far-reaching injunction, applicable to the six states in the Chicago region, against continued application of this presumption. The court ordered SSA to restore benefits to all mentally disabled persons who were adversely affected by CDIs since March 1981 and to-evaluate their eligibility.

Documentation of almost identical practices in Utah and New York demonstrates that the policy of presumption was not the "aberration" SSA claimed in its defense, only practices in the Chicago region, but a firm national SSA policy—one which has been in placed for several years. As early as August 1978, the chief consulting psychiatrist in the New York regional office, Dr. Anne Geller, wrote: "It is clear that whether a claimant can withstand the stress of work or not is never a consideration. Unfortunately these are the guidelines we have to follow even though common sense and psychiatric experience dictate otherwise." She went on to say, "I therefore conclude that in younger workers medical-vocational allowances are not considered when the impairment is psychiatric." [Internal memorandum, N.Y. Regional Office, August 24, 1978] In Utah MHLP is halfway through a review of all CDI cases of mentally impaired persons and have yet to see one disability finding based on a medical-vocational evaluation.

We believe that such neglect of the required sequential evaluation process can be corrected only through legislation. In H.R. 2987, several amendment sections require a realistic evaluation of each claimant's ability to work. For mentally disabled individuals, section 104 requires a work evaluation, at an actual or simulated work site. We endorse this requirement, and further urge committee report language to make clear that an appropriate work evaluation must include (1) an in-depth interview to obtain a claimant's detailed work, education and social history; (2) a comprehensive medical and psychological evaluation; (3) vocational and work-sample testing to determine how the individual performs in an actual or simulated work setting; and (4) where a physical impairment exists in addition to a mental impairment, an evaluation of physical capacity performed by a licensed occupational therapist under the direction of a physician.

The Shannon-Stark bill, in section 105, would also prohibit the practice of improperly equating the capacity to do sheltered work with ability to hold a competitive job. The amendment recognizes the substantial differences between success in a nonstressful, supportive workshop environment and success in the competitive job market. Insights about the individual's performance and capabilities could still be used to assist SSA in reaching a decision, but no one could be presumed capable of working simply by virtue of participation in noncompetitive work.

A third provision related to the determination of ability to work is addressed in section 204 of the bill. This section requires SSA to consider the complete medical and vocational history of the applicant including all evidence in the file from prior evaluations. In situations of long-term illness—particularly chronic mental illness, which often follows an erratic course—SSA has mistakenly accepted temporary improvement as representing an end to the disability.

II. A NUMBER OF SSA'S PROCEDURES MUST BE IMPROVED, CHANGED OR OTHERWISE REVISED TO ASSURE THAT APPLICANTS' AND RECIPIENTS' CASES ARE HANDLED EXPEDITIOUSLY AND FAIRLY

There are a number of procedural problems which this Subcommittee should address. These include:

A. SSA's failure (and refusal) to follow the Administrative Procedure Act (APA) in issuing new policy and changes in policy;

B. SSA's refusal to follow circuit courts of appeals decisions, instead "non-acquiescing;"

C. SSA's has not issued regulations for the states to utilize in making consultative examination referrals or monitoring the process.

Finally, we discuss briefly in (D) our concerns with the face-to-face interview at the reconsideration level of review.

A. Statutory language should make clear that SSA must follow the public notice and comment requirements of the APA

Despite the fact that SSA, as with all of HHS, has been under the Administrative Procedure Act since 1970 by order of then-Secretary of Health, Education and Welfare Elliot Richardson, SSA persists in ignoring its obligations pursuant to the APA. In particular, SSA issues new policy directives at low levels of the agency without first having published the changes in the FEDERAL REGISTER and obtaining public comment. SSA's own regulations admit to this practice. 20 C.F.R. § 422.406(a)(4) specifically states that the "Social Security Rulings" include "statements of policy and interpretations which have been adopted but have *not* been published in the Federal Register . . ." [Emphasis added.]

There is a very definite need for uniformity of decisionmaking between the various levels of review within SSA. Apparently recognizing that use of the lowliest of SSA documents to issue policy (such as the Program Operations Manual System, Informational Digest, and quality assurance "returns" [11]), may not be acceptable to the Congress or the courts, SSA in the past year has moved toward utilizing the "Social Security Rulings" as the source of all policy. As noted earlier, Rulings contain policy never published in the FEDERAL REGISTER or the federal regulations. They have also been the vehicle for SSA's formal rulings of non-acquiescence. (See, pp. 19–23.)

The Rulings are not the answer to SSA's or beneficiaries' problems with the system. The public notice and comment process is well-suited to SAA's needs.

Due to the size of the Social Security and SSI programs, there are many individuals and organizations with substantial expertise whose opinions and suggestions should be considered, with the likely result of changes or modifications being made in proposals. With rare exceptions for those instances when there is no time for public comment before implementation, it is generally more useful for SSA or any agency to receive comments before a proposal is implemented, before the agency is locked-in administratively to a particular program or approach.

We have no reason to believe that the process for issuing policy changes will be any longer or shorter than the time which SSA currently takes to issue proposed regulations, Social Security Rulings, or other memos. In some cases, the time seems to vascillate wildly, depending upon SSA's motivation. For example, last August SSA issued interim final regulations exempting burial trusts from resources in SSI, long before a somewhat similar statutory provision had even been enacted, but only shortly after the plight of an elderly woman, Mattie Dudley, became national news. At the opposite end of the spectrum, it appears that some of the Rulings issued by SSA recently have been in the drafting stages for at least a year. Given this time frame, there is no excuse for not seeking and obtaining public comment. Proof of SSA's capabilities in quick drafting and issuance of materials was provided to us in somewhat unusual fashion last September. On September 20, 1982, SSA issued a "delayed implementation transmittal" to all SSA staff.[12] In that transmittal, SSA informed local SSA offices that it expected to obtain authority, through either the 1983 appropriations bill or a continuing resolution, to suspend its obligation under § 206 of the Social Security Act, 42 U.S.C. § 406, to withhold 25 percent of a back award to assure that a private attorney's fees are paid. The 18-page, single-spaced, memo detailed how this policy would affect even fees already awarded but not yet paid. SSA had no legislative authority for the transmittal when it was issued nor did it ever receive it. Yet, upon the expectation that it would obtain such authority, SSA staff churned out one of the most detailed, comprehensive documents it has issued in recent years. We can only conclude that, when motivated to do so, SSA can streamline its process and easily obtain the benefit of public comment. We encourage this Subcommittee to require SSA to utilize the APA fully rather than simply acquiescing to its current sluggish, inverted mechanisms for creating and establishing policy.

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[11] See *Mental Health Association of Minnesota* v. *Schweiker*, 554 F. Supp. 157 (D. Minn. 1982).
[12] SSA Pub. No. 68–0203910 (Sept. 20, 1982).

B. SSA should be required to follow the decisions of the Circuit Courts of Appeals unless they are overruled by the Supreme Court

NSCLC has addressed this problem in some detail in previous testimony before this Subcommittee and the Social Security Subcommittee.[13] Despite the arrogance and illegality of SSA's policy of non-acquiescing in the decisions of Circuit Courts of Appeals, SSA persists in defending it and continuing its use.

SSA's non-acquiescence policy takes two forms. First, SSA issues "Social Security Rulings" in which it will set forth a circuit court's decision and then state that "SSA *holds* that" it will not follow the court's order. (emphasis in original) This is known in the field as "formal non-acquiescence." Second, SSA simply ignores many decisions of Circuit Courts with which it disagrees, "informal non-acquiescence". This has happened on subjects such as the consideration of pain, weight to be given a treating physician's report, and evaluation of alcoholism. Regardless of the form, the practice should be eliminated.

At least four courts have now considered the issue and have ruled SSA's practice null and void; SSA is bound to follow the law of the circuit. *Lopez* v. *Heckler,* Civ. No. 83-0697-WPG(T) (C.D.Cal. June 16, 1983); *Siedlecki* v. *Schweiker,* Civ. Action No. C82-61R (W.D.Wash. January 28, 1983); Chee v. Schweiker, No. CIV-82-693-PCT-VAC (D.Ariz. December 14, 1982); Hollingsworth v. Schweiker, No. N81-0035C (E.D.Mo. March 3, 1983). In *Lopez,* the court stated, "[F]or the Secretary to make the general assertion that a decision of the Court of Appeals is not to be followed because she disagrees with it is to operate outside the law." As a result of this court's order, approximately 72,000 individuals terminated from the OASDI and SSI disability programs who reside within the Ninth Circuit are now entitled to have their cases redetermined under the standards enunciated in *Finnegan* v. *Mathews,* 641 F.2d 1340 (9th Cir. 1981), and *Patti* v. *Schweiker,* 669 F.2d 582 (9th Cir. 1982).

A statutory prohibition against SSA's non-acquiescence policy is critical. Without it, SSA will continue to hold itself above the law. Two concerns are sometimes raised when SSA's non-acquiescence policy is addressed. First, doesn't the IRS issue rulings of non-acquiescence? Second, if SSA is to be a nationwide program, shouldn't it be administered uniformly?

The Internal Revenue Service does have a non-acquiescence policy. However, it is very different and more sensible than SSA's. For example, if the IRS issues a ruling stating that it non-acquiesces in a circuit court's decision, that ruling is applicable outside of that circuit. The IRS will follow the circuit court's decision within the circuit. SSA, of course, issues its ruling of non-acquiescence to assure that no one within the jurisdiction of the Circuit Court will follow the court's decision.

On the question of nationwide uniformity, it should be noted that the policy considerations in support of nationwide taxation policies are no less substantial than those favoring nationwide standards in Social Security. In *Califano* v. *Yamasaki,* 442 U.S. 682,669 (1979), SSA informed the Supreme Court that it would follow the decisions of circuit courts of appeals, regardless of whether a class had been certified. "Restricted judicial review will not have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by] them within the jurisdiction of the courts rendering them." Further, in the same case, in an effort to avoid certification of a nationwide class, SSA argued for the need for diversity of circuit court opinions:

"[The Secretary] argues that a nationwide class is unwise in that *it forecloses reasoned consideration of the same issues by other federal courts* and artificially increases the pressure on the docket of this Court by endowing with national importance issues that, if adjudicated in a narrower context, might not require our immediate attention." 442 U.S. at 701-702.

SSA cannot have it both ways. Based upon its own representation, SSA is not really that concerned about the uniformity issue. While it is desirable that the program be administered uniformly nationwide, it is more desirable that SSA follow the law of the Circuit within that Circuit until such time as the Supreme Court rules to the contrary in that case or another case raising the same issue.

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[13] Administration's Fiscal Year 1983 Legislative Proposals for Unemployed Compensation and Public Assistance," Hearings Before the Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means, Mar. 25, Apr. 21 and 22, 1982, Serial 97-62, pp. 875-876; "Social Security Appeals and Case Review Process," Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, Oct. 23 and 28, 1981, Serial 97-31, pp. 200-209, in particular pp. 206-207; "Disability Amendments of 1982," Hearings before the Subcommittee on Social Security of the Committee on Ways and Means on H.R. 5700, Mar. 16 and 17, 1982, serial 97-54, pp. 209-230, particularly 218-220, 228-230.

The Social Security Subcommittee's bill provides, at this time, that SSA will be required to acquiesce only in cases decided after the date of enactment of the bill. While appropriate Committee Report language should clarify that this language is not intended to prevent courts from enforcing earlier Circuit Court decisions, it would be much more helpful if the bill itself simply required SSA to follow all Circuit Court decisions until such time as they appeal and prevail or a case on the same issue is decided to the contrary by the Supreme Court. This will ensure that SSA follows the many important Circuit Court decisions which it today ignores on issues such as pain, alcoholism, obesity, the weight to be accorded a treating physician's report, and the ALJ's obligation to assist an unrepresented claimant.

The Social Security Subcommittee's bill also includes language which essentially provides SSA with an automatic stay of a Circuit Court's order any time it files an appeal with the Supreme Court, until the Court disposes of the case. We believe that this will unnecessarily increase the number of appeals which SSA files in the Supreme Court and will result in claimants and recipients being denied the benefit of helpful court decisions for many months, in some cases over a year. We recommend that this language be deleted from the bill. If substitute language is required, we recommend that it state that SSA is obligated to implement the court's order unless it seeks and obtains a stay from either that court or the Surpreme Court as provided for in Federal Rules of Appellate Procedure 41(b) and Supreme Court Rule 44.

C. SSA should be specifically required by statute to issue regulations governing the use and monitoring of consultative examinations

§ 304 of Public Law 96-265, the Social Security Amendments of 1980, provided that the Secretary of HHS "shall promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States." When SSA did issue proposed regulations governing the federal-state agency relationship, it did not mention consultative examinations (CE) or set standards for their utilization. This is so despite the incredibly high administrative cost incurred in paying for CEs, over $137 million in 1981 alone.[14] (As the number of CDI reviews increased last year, it is likely that this figure increased substantially in 1982.)

The problems with the CE process have been documented at numerous earlier hearings within the Committee, including those focusing solely on the volume provider CE problems. We are aware that SSA has recently prepared a sheet which describes in the vaguest of terms the steps which it has taken in this area. While it is impossible for use to tell from the sheet whether SSA has made significant changes, the calls to our offices regarding the poor quality of CE decisions have not been reduced. Further, there is no mention of the issuance of regulations.

We are aware of lawsuits being filed against HHS, state agencies and CEs by the surviving spouses of disabled workers who died shortly after a CE said they were not disabled and SSA teminated their benefits. It is unfortunate that such suits must be filed, particularly for the disabled worker who cannot regain his life, but if SSA does not regulate this area and improve the quality of CE evaluations, it is reasonable to expect that the litigation in this area will increase.

We support the language included in the Social Security Subcommittee's bill requiring SSA to issue regulations on the on the CE issue.

D. The face-to-face interview should be conducted at the intial level of review

H.R. 2937 includes a provision which will move the face-to-face interview up to the intial level of review. The disabled person will be interviewed, acutally observed and listened to, by the state agency official adjudicating the persons's case. This provision should increase the quality of decisionmaking at the initial level and obviate the need for many of the appeals currently being filed.

We do not believe that a face-to-face interview at the reconsideration level serves the same purposes. It will take place only after there has been a decision against the applicant or recipient. It is far more logical to obtain the most complete evidence development, including a meeting with the applicant or recipient, at the earliest stage possible.

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[14] Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, "Volume Providers of Medical Examinations for Social Security Disability Programs," Ways and Means Committee, Serial 97-27, p. 12 (Sept. 21, 1981).

We are also concerned about the implications which creation of this level of review have for continuation of aid pending an ALJ's decision. Currently, SSI benefits continue through the ALJ level; there is no reconsideration level in SSI disability termination cases. It is our understanding that SSA now intends to include a reconsideration level for these SSI cases and only pay aid pending through this level. While there may be some constitutional problems with this approach, it also does not represent good public policy. As the ALJ level is the first level at which an individual's case is reviewed by an impartial trier of fact whose job is secured by statute for life, it is more appropriate to provide aid pending through this level where the highest degree of accuracy and fairness are assured. In order to assure that SSA does not make this drastic change in the SSI appellate process, we recommend that the requirement that SSI benefits be continued through the ALJ level should be specifically included in the statute.

SSA has recently completed a pilot project regarding face-to-face at the reconsideration level. It should be noted that while the pilot projects reflected a higher reversal rate (34 percent) than had previously existed at the reconsideration level, almost half of that figure reflects reversals made by the state agency before the file had even been sent to the federal level for the face-to-face interview. It is reasonable to expect that the reversal rate will be substantially less when the initial interest in the new level dissipates. Second, SSA staff have indicated a belief that the reconsideration decisions can be completely expeditious, within two months. This is extremely convenient: currently, by statute, OASDI disability benefits continue for two months after the date of cessation. In other words, there would be no real right to aid pending in OASDI (and an absolute reduction in SSI). In addition, we expect that, given the convenience of this time frame, there would be a great deal of pressure to issue decisions within the two month period, even where the files had not been fully developed and/or fully reviewed. The possibilities for abuse are substantial. At a minimum, it would be helpful if aid paid pending the ALJ level is continued for the next two to three years until the experience with this new level of review, if it is retained, is fully understood.

We are very concerned that the Social Security Subcommittee's bill will only permit those who appeared for a face-to-face interview at the initial level to appeal unfavorable decisions to the ALJ level. This will work the greatest hardships for those who have great difficulty in understanding or reading notices and/or in physically appearing at an interview site. It is also inconsistent with SSA's own practices at the ALJ level. Waiver or the right to appear at that level does not mean that the individual forfeits his/her right to seek further review. It simply means that a paper review will be the sole basis for the decision made at that level. See 20 C.F.R. § 404.948(b); § 416.1448(b). We recommend that this language be deleted from the Social Security Subcommittee's bill.

III. MISCELLANEOUS CONCERNS

There is one additional issue which we believe the Subcommittee should consider: SSA has not properly implemented § 301 of Pub. L. 96-265, which provided for continued eligibility for benefits even though the person's impairment has ceased where the person is involved in a vocational rehabilitation program.

SSA is violating § 301 of Pub. L. 96-265, the 1980 amendments.—While SSA has relied heavily upon Congress' role in 1980 and the alleged Congressional intent in justifying its behavior with the CDIs, SSA has completely obstructed the effects of one provision of Pub. L. 96-265 designed to assure that those seeking to improve their skills and thus eliminate their reliance upon disability benefits are not discouraged from taking such steps.

Section 301 of the 1980 Social Security amendments, Pub. L. 96-265, [42 U.S.C. § 425(b) and § 1383(a)(6)] provides that SSA cannot terminate the benefits of a person whose physical or mental impairment has ceased if the person is participating in an approved voc rehab program and SSA determines that involvement in the voc rehab program will increase the likelihood that the person may ultimately be permanently removed from the disability program. But, SSA added an extra requirement in its regulations. 20 C.F.R. § 416.1338(a)(4) only permits benefits to continue in cases where, at the time the person began voc rehab, he/she was "not expected to recover medically before the scheduled completion date of the program." SSA has taken the position that a person whose case was diaried for review on the expectation that there could be improvement is not entitled to the benefits of Section 301 due to § 416.1338(a)(4).

Two cases have challenged this policy. *Leshniok* v. *Schwieker,* Civ. No. 82 308 PHX CCH (D. Ariz.), is pending in the Ninth Circuit Court of Appeals. In *Paskel* v.

Heckler, No. 83-1201 (E.D. Pa.), the district court has granted the individual plaintiff's motion for declaratory and injunctive relief. The court held:

"42 U.S.C. § 1383(a)(6) provides that even if a disability beneficiary's impairment has ceased, that individual shall not be terminated if he or she is participating in an approved vocational rehabilitation program and 'the Commissioner of Social Security determines that the completion of such program . . . will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls.' Id. The language of this statute is clear on its face. In plain and unmistakable words, free of ambiquity or qualification, it states that persons in vocational rehabilitation programs (which includes the plaintiff) are entitled to a 'likelihood' determination before their benefits are terminated."

Date stipulated to by SSA in *Paskel* reflects the enormity of the problems.[15] Despite the fact that thousands of OASDI and SSI disabled beneficiaries in Pennsylvania are actively participating in approved state vocational rehabilitation programs, and despite the fact that hundreds are subjected to CDI reviews each year and many more will be reviewed as a result of the diary process, SSA only performed 4 evaluations in Pennsylvania under § 301 in all of 1982, only 2 of which are granted.

The statute should be clarified to assure that SSA properly reviews cases under § 301.

IV. SECRETARY HECKLER'S RECENT PROPOSALS DO NOT ADDRESS THE PROBLEMS FACED BY MOST DISABILITY BENEFICIARIES SUBJECTED TO CDI REVIEW

The following is a brief discussion of each of Secretary Heckler's recent proposals along with our concerns about each.

A. SSA has identified new categories of "permanently disabled" individuals who, by virtue of this recategorization, will be exempt from CDI review

We welcome any effort to identify more disabilities as permanently disabling. However, it is very important that the Congress focus on the types of impairments which SSA is now, for the very first time, identifying as permanently disabling. The additions to the list include:[16]

Ischemic heart disease with chest pain of cardiac origin;

Parkinsonian syndrome, with disturbance of movement, gait, or station as required by the applicable listing (at any age, not just over age 59);

Anterior poliomyelitis, with interference in swallowing, breathing, speech, or motor function as described in the applicable listing (at any age, not just over age 59);

Chronic brain syndrome (organic brain syndrome) with manifestations as required by the applicable listing;

Functional psychotic disorders if institutionalized in a licensed mental hospital for past 12 months without releases that would indicate improvement; and

Mental retardation, with IQ of 60 to 69 and another physical or mental impairment

It is troubling to imagine that anyone, much less SSA, had difficulty in determining that these impairments were permanently disabling. Yet, less than just two months ago, and since March 1981, SSA has been reviewing the cases of individuals with exactly these impairments and, we believe, terminating many of their cases. One can only wonder how many of the deaths after notice of termination could have been prevented had SSA not been so eager to terminate so many. Given this SSA action at this late date, SSA should be required to go back and review the cases of recipients whose benefits were terminated who suffer from impairments just added to this list. As noted earlier, this category has the benefit of a medical improvement standard not available to the vast majority of OASDI and SSI beneficiaries. If they had originally been in that category, in all likelihood, their benefits would still be being paid. But, those who did not have the benefit of the medical improvement standard were often told instead that their impairments were "not severe." These cases that were terminated should be reviewed immediately and benefits should be reinstated.

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[15] "Stipulation" dated June 13, 1983, *Paskel* v. *Heckler*, Civil Action No. 83-1201 (E.D.Pa.).

[16] Source: "Emergency DI/SSI Instructions," OD-83-145 (1027), IT-159-83, June 11, 1983 ("corrected copy").

B. SSA will propose legislation that benefits be continued through the reconsideration level of review and that SSA will be required to review state agency decisions denying benefits as well as allowing benefits

The problems with providing aid pending only through the reconsideration level are discussed earlier in our testimony. Further, while the terms of Pub. L. 97-455 are temporary, this proposal represents a cut from the current payment scheme.

We agree that it would be helpful for SSA to review state agency denials as well as allowances. It is our understanding that SSA is already doing that to some extent. This proposal was first made over one year ago at this Subcommittee's hearing on March 16, 1982 by Commissioner Svahn.

C. SSA will "study" whether changes should be made with regard to evaluation of severity of impairment and possible use of a medical improvement standard

These issues are discussed earlier in our statement. The time for "study" of these issues was exhausted long ago. SSA has been involved in litigation on these issues and has lobbied the Congress with regard to various formulations of solutions. In addition, it has ongoing familiarity with the "medical improvement" standard. The Subcommittee should adopt the provisions of H.R. 2987 which address these issues.

D. SSA will no longer rely upon the computer "profile" currently used to identify cases for CDI review and will instead use a random sample

We believe that at this point eliminating the profile is a hollow gesture. The profile is weighted for younger workers with high earnings before they were disabled. As a result, after over two years of use, it has generally already exhausted its usefulness. While SSA points out that the profile weighs factors such as age and previous earnings and therefore will continue to move up the age and down the earnings scales, they are not able to state how many people will benefit from the shift. Over two years into the process, there probably is no difference between the profile and a random sample.

E. SSA will "pause" CDI review of 135,000 people who suffer from "functional psychotic disorders" while SSA reviews the standards it had been utilizing in these cases

A moratorium or pause on the CDI reviews of mentally impaired individuals' cases makes sense if one looks at the 50 percent appeal rate to the ALJ level. We assume that this rate is so low not because SSA is accurately deciding cases but because confused people, largely with mental impairments, are not protecting their right to appeal. Recent court decisions requiring SSA to reopen decisions where mentally impaired individuals failed to appeal support this analysis. See, for example, *Penner* v. *Schweiker*, No. 82-5337 (3d Cir. February 28, 1983); *Kapp* v. *Schweiker*, 556 F.Supp. 10 (N.D.Cal. 1981); *Brittingham* v. *Schweiker*, Civil Action No. 82-4632 (E.D.Pa. February 7, 1983).

The Secretary's proposal raises two concerns. First, it seems inappropriate to distinguish among the mentally impaired. Further, as a practical matter, if SSA's decisions as to who will be entitled to a "pause" are based upon its often shoddily developed records, SSA is likely to deny a pause where it should be granted.

Second, we are concerned that any pause or moratorium for the mentally impaired not simply result in more physically impaired people's cases being rushed through the CDI process. It would be helpful if SSA simply reduced the overall number of CDIs which it expects to complete this year.

CONCLUSION

The problems in the SSI and OASDI programs are serious and extensive. The Social Security Subcommittee is currently taking steps which, if enacted, will remedy some of the problems in the DI program. This Subcommittee should act to assure that SSI applicants and recipients are protected in that bill and should also take steps to strengthen and improve some portions of the bill, as noted in our statement.

Thank you for inviting us to testify today.

Mr. PEASE. Thank you very much, Mr. Manes.

I appreciate the testimony of all the members of the panel. I sort of get the impression that in regard to the special provision for handicapped people being able to stay in medicaid, that the problem is not the law, the problem is ignorance of the law. Is that a correct statement?

Ms. SMITH. True. Yes, sir.

Mr. PEASE. So you are not suggesting at this point any change in the law in that regard.

[Ms. Smith nods negatively.]

Ms. BOGGS. Well, except that we want it extended. It has a sunset on it now.

Mr. PEASE. You would like it extended, but not changed in the process.

[Ms. Smith nods affirmatively.]

Mr. PEASE. OK. I saw some statistics in the last couple of days about the number of people nationwide who have used that provision, and I was really surprised at how few people have, but if no one knows about it, that would be one explanation of why it is not being used.

Ms. SMITH. That is true. As of Friday afternoon, in my conversations with the area supervisor for the medicaid office, I ended up having to call the director of medicaid in Richmond, who then referred me to the associate commissioner of the Department of Health, and he was the individual who knew about 1619, and he reported there are eight people on 1619 in the entire State of Virginia, but that the individual who was in charge, the commissioner of medicaid, was not knowledgeable as far as the law was concerned.

Mr. PEASE. Do you have any basis for forming a judgment as to whether the department is deliberately misrepresenting this information, or if it is just inefficiency on their part?

Ms. SMITH. I believe it is.

Ms. BOGGS. I think it is that the SSA did not give high priority to 1619. The thing was enacted just before a change in administration. There was reorganization in SSA, and from their point of view this was less important than getting people off the rolls entirely.

Mr. PEASE. This committee has been very concerned for quite some time about the dilemma of people losing medicaid. It is great to encourage people to go back to work, whether they are handicapped, unemployed, or any other program, but the thing we keep running into is that people cannot afford to go back to work or try work because the trauma of losing medicaid cards is so great. The provisions we have been discussing today were really designed to help that situation, and it is a real disappointment that the administration is not making greater reference to see that that provision is used.

Ms. BOGGS. I also think there is some deterrence at the State level when you have a program of such short duration. As I said, for me to recommend to someone that they go on to this program now, not knowing whether it would be continued past December 31, I would have to counsel the individual about the risks. We hope this bill will go through, but we would have that uncertainty. Furthermore, the final regulations were only issued a few months ago. So that is a disincentive to State medicaid directors. They do not take things seriously until they have final regulations as a rule. So all of those things, I think, have contributed to the failure to implement this provision, and it stresses the importance of giving it a longer period of time.

Mr. PEASE. All right. Well, I think you will find certainly this subcommittee sympathetic to an extension of that provision.

If there is nothing further, let me again thank the panel and all of the witnesses this morning, and declare this hearing at an end.

[Whereupon, at 1:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

ASSOCIATED STAFF ATTORNEYS, OFFICE OF HEARINGS AND APPEALS,
NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224,
Wichita, Kans., June 24, 1983.

Hon. FORTNEY H. STARK,
U.S. House of Representatives,
Longworth H.O.B., Washington, D.C.

DEAR MR. STARK: You were recently quoted in the news media, stating that the Social Security disability program is run with the "heart of a Doberman pinscher and the mind of a piranha." After six years as a staff attorney with the Office of Hearings & Appeals, SSA, I conclude that your assessment is accurate.

For your information, I have attached herewith a copy of my letter to Senator William Cohen, chairman of the subcommittee on Oversight of Government Management. You may use the letter in any way which will properly bring SSA management abuses to light in order to protect the public interest.

Thank you for your consideration.

Sincerely,

RICHARD J. PECKHAM,
Staff Attorney.

ASSOCIATED STAFF ATTORNEYS, OFFICE OF HEARINGS AND APPEALS,
NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224,
Wichita, Kans., June 4, 1983.

Re social security disability problems.

Hon. WILLIAM S. COHEN,
U.S. Senate, Chairman, Committee on Oversight of Government Management, Washington, D.C.

DEAR SENATOR COHEN: As a staff attorney employed by the Office of Hearings & Appeals (OHA), Social Security Administration (SSA), 400 N. Woodlawn, Wichita, Kansas, I write to advise you of improper SSA/OHA management practices which bear adversely upon the processing of Social Security disability benefit claims filed under the provisions of Titles II and XVI of the Social Security Act.

In the course of my work for OHA, I have examined approximately 2,000 disability claim files and drafted as many post-hearing decisions for Administrative Law Judges during the past six years. As executive vice president and chief steward of the Associated Staff Attorneys, I receive information regularly from staff attorneys and administrative law judges throughout the nation advising me of local, regional and national management practices instituted by the Social Security Administration concerning the disability benefit program.

In the normal course of my assigned duties at OHA I have studied much of the federal case law bearing upon both the substance of Social Security disability benefit entitlement and the fairness of the administrative procedures which confront disability claimants.

I conclude that many of the Social Security disability claims policies and procedures, as designed by SSA/OHA, deny fairness and due process of law to thousands of American citizens who apply annually for benefits. The Social Security Administration is treating claimants and their cases as if they are standardized piece-work in a machine shop, rather than human beings requiring careful individual examination.

Consider the following:

1. DISABILITY STANDARD IS IMPROPER

The Social Security Administration is applying an overly restrictive standard of disability, more severe than the law demands or Congress intended by enactment of Titles II and XVI of the Act. This is done by requiring each claimant to "meet or equal" the medical criteria found in the "Listing of Impairments", appendix 1 of the Social Security Regulations. This unrealistic standard, promulgated by SSA, is de-

signed to facilitate administrative convenience and speed case processing; however, it prevents an individualized approach to each case.

Further, at the initial claim consideration level (state agency), the claimant is not even seen by the "examiner" who determines his claim status.

2. CASE PROCESSING: SPEED VERSUS QUALITY

Social Security employees, including OHA staff attorneys and Administrative Law Judges, are given performance ratings based almost entirely upon speed of processing claim files. Thus, careful analysis and appropriate development of evidence, necessary to fair claims adjudication, are clearly discouraged. For example, OHA staff attorneys are required to complete work on each claim file at the minimum rate of one every four hours, or face disciplinary action and discharge.

I have personally observed that management pressure for speed has discouraged Administrative Law Judges from ordering consultative medical examinations which are often necessary due to poor evidentiary development at lower administrative levels (state agencies).

OHA hearing offices are evaluated by SSA management exclusively on the basis of the number of cases completed per month. The Associate Commissioner of Social Security for Hearings & Appeals, and senior executive service personnel, become eligible for annual performance bonuses based upon reaching pre-determined regional and national case processing quotas, not for the quality of work done.

The pressure for high volume case processing becomes feverish approaching the month of September each year, just before "bonus" time. As a result of the management pressures, many OHA offices have been reduced to falsifying monthly production reports in order to inflate the "case count."

Example: management personnel in the Minneapolis, Minnesota OHA hearing office "back-dated" disability hearing decisions which were issued in October 1982 in order to fatten the September case count, thereby cheating the claimants out of part of their 60-day statutory right to appeal the denial of benefits. The 60-day limit on right of appeal commences from the date the claimant is presumed to have received the decision, which is normally 5 days after the date appearing on the decision. After failing to appeal the decision within the 60-day period, the claimant loses all opportunity for review of his claim with respect to the current application.

The back-dating of hearing decisions in Minneapolis, despite the objections of Administrative Law Judges and staff attorneys in that office, is no isolated episode. This practice can be found in many OHA offices throughout the nation, in response to improper pressures from SSA/OHA management officials in Baltimore, Maryland and Arlington, Virginia.

It is also common practice, in those months in which an OHA office has met its case quota, to hold "excess" decisions and to mail them during the following lean month. This "stock piling" of decisions is another symptom of improper quota pressures. Obviously, the claimant must wait until administrative convenience is satisfied before receiving his or her case decision.

These problems are the natural result, in part, of the "Performance Based" employee evaluation systems implemented by the Office of Personnel Management, and massive fears of large Social Security disability case backlogs. In recent years the increase in disability benefit claims has been dramatic, however the Social Security Administration has not maintained sufficient staffing to process the claims properly.

"Productivity," in the Social Security disability claims processing and appeals system, is defined exclusively in terms of speed, not quality. The result is that thousands of claimants do not receive fair consideration, especially at the lower levels (state agencies) which are not protected by the Administrative Procedures Act.

This unfair and inefficient claims system generates endless claimant appeals, paid for by the taxpayers. These problems have developed as the result of administrative policy decisions which have accumulated over a period of more than a decade, and therefore the blame cannot be laid at the feet of any single Presidential administration. I have good reason to believe that these opinions are shared by the majority of the 800 Administrative Law Judges and 400 staff attorneys employed in OHA offices spread throughout the nation.

I recommend legislative action to accomplish the following remedial objectives:

1. Amend the Social Security Act, clarifying the definition of disability with greater specificity, thereby reducing bureaucratic latitude and political influence.

2. Separate the corps of Administrative Law Judges from the administrative fiat and political influence of the Social Security Administration, as proposed in Senate Bill 1275.

3. Create a federal Social Security Court, an Article III speciality appellate court (like the Tax Court), completely insulated from executive branch influence or control, for purposes of establishing a consistent body of case law concerning both substance and procedure for all claims arising under the Social Security Act.

4. A directive, mandating the Office of Personnel Management to implement regulations specifying methods of evaluating Social Security Administration employees based primarily upon quality of performance, and insulating those employees from improper agency pressures for speed.

5. Appointment of the Commissioner of Social Security and Associate Commissioners through a bipartisan congressional committee, in order to avoid selection of unqualified persons based on political factors.

6. Legislation specifying minimum SSA personnel staffing levels, linked to national and regional case-load factors, to insure sufficient numbers of personnel to process SSA claims properly at all levels.

These measures, combined with the constant vigilance of the Congressional oversight committees, will help restore integrity and quality to the Social Security Disability program. Your consideration is greatly appreciated.

Sincerely,

RICHARD J. PECKHAM,
Executive Vice President.

STATEMENT OF THE INTERNATIONAL ASSOCIATION OF PSYCHO-SOCIAL REHABILITATION SERVICES

This statement is submitted on behalf of the International Association of Psycho-Social Rehabilitation Services (IAPSRS), a national organization representing approximately 300 agencies and individuals who furnish psycho-social rehabilitation services to psychiatrically-disabled adults. IAPSRS goals are to advance the role, scope and quality of services designed to facilitate the community readjustment of the psychiatrically disabled individual. Many of the clients in psycho-social rehabilitation programs are individuals who receive social security disability insurance and/or supplemental security income payments.

IAPSRS strongly supports the provisions in H.R. 2345 and H.R. 3074 which would make permanent the three-year pilot project authorized under Section 1619 (A) and (B) of the Social Security Act. This section, enacted in 1980, provides broadened opportunities for disabled people to return to work and provides incentives for them to do so. Under these provisions, SSI recipients who work are eligible for special cash payments and SSI-eligibility if their earnings are above the substantial gainful activity level; their countable income is under the level at which an SSI recipient would become ineligible based on income alone; and they continue to have a disabling impairment. This also allows those who are disabled to retain their Medicaid eligibility, without which many chronically mentally ill individuals would be unable to continue to receive the essential medical care they require (especially medications and necessary monitoring of medications). Cash benefits can also be continued beyond the breakeven point, and medicaid eligibility may also be retained if the Secretary finds that ending these benefits would impair a client's ability to continue to be employed.

This program gives disabled SSI recipients every incentive to seek employment. It ensures a safety net of benefits and the services which are essential if a chronically mentally ill person is to work in a sheltered workshop or a competitive job. In the long term, incentives such as these save the government substantial sums. Institutional costs are reduced, cash benefits are reduced and the clients are able to become more productive and better adjusted members of society.

IAPSRS strongly urges the Committee to make these important provisions a permanent part of the SSI program.

In addition, we would like to discuss briefly the problems which have arisen for SSI-eligible individuals under the Administration's hasty and arbitrary continuing disability reviews.

The mentally ill have been especially hard hit by these reviews. The selection of individuals for review, the inadequacy of Social Security's criteria concerning mental illness, the perfunctory reviews which fail to seek out sufficient medical and other evidence, the failure of SSA to make realistic work evaluations, have all taken a tremendous toll on this population. Moreover, many chronically mentally ill people are at a severe disadvantage in trying to cope with the bureaucratic system. As a result, data from the SSDI program show that while only 11 percent of those

on the rolls are mentally disabled, the mentally disabled represent 28 percent of those being terminated.

It has, at the same time, suddenly become much more difficult to establish eligibility for SSI on the basis of a mental disability. This policy has a devastating impact on patients ready to be discharged from a state hospital for whom SSI payments are the only possible resource to support themselves in any way in a community alternative. Even when appropriate services are available, lack of income is keeping patients locked in state hospitals, at considerable financial cost to society and at cross purposes with local efforts at deinstitutionalization.

Clearly, mentally disabled persons are being denied essential benefits to which they are fully entitled, and this is supported by the extremely high rate of reversal at the appeals level.

The Social Security Subcommittee is now working on a bill to redress these problems. We urge this subcommittee to join forces with the Subcommittee on Social Security to seek common solutions to the problems under the disability programs. We strongly endorse the bill introduced by Congressmen Shannon and Stark to reform the SSDI program, and believe the bill which will emerge from the Social Security Subcommittee will address the major issues in the Shannon-Stark bill. Particularly important for the mentally ill are the provisions which:

Establish criteria which must be used before someone is terminated from the disability rolls (medical improvement).

Establish a moratorium on reviews of mentally disabled persons, while requiring to work with outside experts to revise their criteria in this area.

Require adequate consideration of the effects of multiple-impairments.

Continue benefits through appeal.

Require that either a psychiatrist or a psychologist review the case and make the final determination regarding eligibility in all cases which may otherwise be denied.

Provide incentives for rehabilitation agencies to serve the disabled population.

Require that SSA's policies be published for public review and comment in the Federal Register.

Encourage SSA to conduct realistic work evaluations of the mentally impaired.

We urge you to make all these provisions applicable to the SSI disabled population.

In addition, trial work, transitional work and vocational rehabilitation present special problems for the SSI population, and may need to be dealt with separately by this subcommittee.

With training and supportive services, many psychiatrically disabled people can be quite productive. The provisions for transitional work and trial work are particularly important to them. The amount of earnings now considered to represent trial work is set at $75 a month. Although this is only one quarter of the amount considered to be substantial gainful employment, it is apparently enough, under current policies, to be evidence that the individual can work. Moreover, the nine-month trial work period is not required to be consecutive, and in many cases SSA counts work done over a period of several years as evidence that the individual can work. Section 305 of the Shannon-Stark bill addressed these concerns. In addition:

Transitional work performed as part of a rehabilitation program (not limited to those under state vocational rehabilitation agencies) should not count as part of trial work.

A month of trial work should be one in which earnings are at least sufficient to entitle the worker to coverage under Title II.

We urge that section 305 and the two additional provisions above be enacted for the SSI population.

Also important under SSI is the access to appropriate vocational rehabilitation services. In 1981 changes were made to this program which limited reimbursement to cases of successful rehabilitation, defined as working for nine continuous months.

Such a goal is totally unrealistic for many chronically mentally ill individuals, who nonetheless can be rehabilitated and thus perform some work, or at least function in a community (instead of an institutional) setting. Since the 1981 amendments, states and agencies have little incentive to serve the SSI population. Some changes will be made by the Social Security Subcommittee: agencies would be paid in the event of medical recovery by a client in a vocational rehabilitation program, and agencies would be paid in cases where the person without good cause fails to accept services. However, this is not sufficient. Language should be added to provide an incentive for rehabilitation agencies to participate. This should be in the form of a payment over cost for successful rehabilitations. Even the best evaluation techniques do not guarantee success, and if agencies are to accept the risk of nonsuccessful rehabilitations, there should be an incentive for doing so.

The Subcommittee should also look at the "successful rehabilitation" standard. Many of the mentally ill benefit from services but do not obtain economic independence and so are generally not referred to vocational rehabilitation services under this program. However, there may still be a net savings for SSI if the services result in the person reaching his or her maximum functional level and income. Placement *in noncompetitive work settings should also, therefore,* be allowed as a "successful rehabilitation."

Finally, we should like to suggest that it would be very valuable to conduct a demonstration project to assess the impact of providing transitional employment training for SSI recipients who are mentally ill. Such a demonstration should be a three-year pilot program, along the lines of the project just being initiated for mentally retarded individuals. Transitional employment, a service provided by many psycho-social rehabilitation agencies, is a very effective tool for helping chronically mentally ill individuals learn the skills they need in order to work. Their problems in this regard are not dissimilar from those of mentally retarded persons, and we believe a pilot project, including a rigorous cost-benefit analysis, should be conducted to focus on the results of training and to compare such results with a control group of recipients who did not receive training.

The project for the mentally retarded is budgeted for $2.8 million; we assume that a similar project for the mentally ill would also be in the region of $3 million.

In conclusion, we urge this Subcommittee to work with the Social Security Subcommittee so as to establish the same reforms for the SSI population as are now being instituted for the SSDI population. Then in addition, we believe the Subcommittee should address separately the issues for the SSI population concerning trial work, transitional work and vocational rehabilitation which we have listed above.

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